ALTERNATIVE MEDICAL LIABILITY ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

SECOND SESSION

ON

H.R. 5400

TO AMEND PART A OF TITLE XVIII TO PROVIDE FOR AN ALTERNATIVE LIABILITY SYSTEM FOR MEDICAL MALPRACTICE IN THE CASE OF INJURIES UNDER MEDICARE AND OTHER FEDERAL PROGRAMS IF STATES FAIL TO PROVIDE FOR ALTERNATIVE LIABILITY SYSTEMS

JUNE 28, 1984

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ALTERNATIVE MEDICAL LIABILITY ACT

THURSDAY, JUNE 28, 1984

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met at 10:12 a.m., pursuant to notice, in room 1100, Longworth House Office Building, Hon. Andy Jacobs, Jr. (chairman of the subcommittee) presiding.

[The press release, a copy of H.R. 5400, and a summary of the bill follow:]

[Press release No. 9, Friday, June 15, 1984]

THE HONORABLE ANDY JACOBS, JR. (D., IND.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, TODAY ANNOUNCED A HEARING ON H.R. 5400, THE ALTERNATIVE MEDICAL LIABILITY ACT, TO BE HELD ON JUNE 28, 1984

The Honorable Andy Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on H.R. 5400, the Alternative Medical Liability Act, introduced by the Honorable W. Henson Moore (R., La.) and the Honorable Richard A. Gephardt (D., Mo.). The hearing will be held on Thursday, June 28, 1984, in Room 1100, Longworth House Office Building, beginning at 10:00 a.m. The bill would amend Title XVIII of the Social Security Act to provide for an alternative liability system for medical malpractice in the case of injuries under medicare and other Federal programs if States fail to provide for alternative liability sytems.

BILL SUMMARY

The legislation encourages States to establish alternative medical liability laws in accordance with certain standards set forth in the legislation. If a State fails to establish such a law prior to January 1, 1987, a Federal system of medical liability would go into effect following substantially the same standards as those established for States. The Federal law would be applicable only to malpractice claims for services provided under medicare, medicaid, the CHAMPUS and CHAMPVA programs, the Federal employees health benefits program and other Federal health programs.

Under the alternative medical liability proposal, if a hospital, physician or other health care provider potentially liable for malpractice tenders to an injured individual within a specified period of time an offer to pay the individual's actual economic loss, the individual would be foreclosed from bringing a civil action for malpractice against the provider or any other person joined in the action. The recovery would be limited to the individual's net economic loss including medical expenses, loss of income from work, rehabilitation costs, and attorneys' fees. The individual could not recover amounts for pain and suffering, physical impairment, punitive damages, loss of consortium or other general damages.

Settlements with a net economic loss exceeding $5,000 must be determined by a court to be fair to the injured individual before the provider is discharged from its liability. If a provider delays by not offering to settle within six months, the patient can sue under the current system. Certain actions for intentional injury and wrongful death would remain unaffected by the bill.

The bill is intended to provide an incentive for hospitals, physicians and other providers to identify and settle potential cases of malpractice. It is intended to reduce malpractice costs by avoiding excessive recoveries while assuring that patients are compensated for their actual losses. It is hoped by the authors of the legislation that the measure will also indirectly minimize the need for defensive medicine which may have the result of increasing overall health care expenditures.

Testimony is requested primarily on H.R. 5400; however, witnesses may wish to comment briefly on alternative approaches to addressing the issues of rising malpractice costs.

DETAILS FOR SUBMISSION OF REQUEST TO BE HEARD

Individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests to be heard by telephone to Harriett Lawler ((202) 225-3627) no later than close of business *Friday, June 22, 1984*, to be followed by a formal written request to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. Notification to those scheduled to appear will be made by telephone as soon as possible after the filing deadline.

In view of the limited time available to hear witnesses, the Committee will not be able to accommodate all requests to be heard. Those persons and organizations not scheduled for an oral appearance will be encouraged to submit written statements for the record of the hearing. All persons requesting to be heard, whether they are scheduled for oral testimony or not, will be notified as soon as possible after the filing deadline.

It is urged that persons and organizations having a common position make every effort to designate one spokesman to represent them in order for the Committee to hear as many points of view as possible. Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing. This process will afford more time for members to question witnesses. In addition, witnesses may be grouped as panelists with strict time limitations for each panelist.

In order to assure the most productive use of the limited amount of time available to question witnesses, witnesses scheduled to appear before the Subcommittee are required to submit 100 copies of their prepared statements to the main Committee office, Room 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearance.

Each statement to be presented to the Subcommittee or any written statement submitted for the record must contain the following information:

1. The name, full address, and capacity in which the witness will appear (as well as a telephone number where he or his designated representative may be reached);
2. A list of any clients or persons, or any organization for whom the witness appears; and
3. A topical outline or summary of comments and recommendations.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six copies are required and may be submitted by the close of business Friday, July 13, 1984, to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Room 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Committee office before the hearing begins.

I

98TH CONGRESS
2D SESSION

H. R. 5400

To amend part A of title XVIII to provide for an alternative liability system for medical malpractice in the case of injuries under medicare and other federal programs if States fail to provide for alternative liability systems.

IN THE HOUSE OF REPRESENTATIVES

APRIL 10, 1984

Mr. MOORE (for himself and Mr. GEPHARDT) introduced the following bill; which was referred jointly to the Committees on Ways and Means, Energy and Commerce, Armed Services, Post Office and Civil Service, and Veterans' Affairs

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A BILL

To amend part A of title XVIII to provide for an alternative liability system for medical malpractice in the case of injuries under medicare and other federal programs if States fail to provide for alternative liability systems.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. This Act may be cited as the "Alternative Medical Liability Act".

SEC. 2. (a) Part A of title XVIII of the Social Security Act is amended—

(1) by inserting the following heading after the heading to part A:

"Subpart I—Hospital Insurance Program", and

(2) by adding at the end the following new subpart:

"Subpart II—Alternative Liability System for Malpractice

"TENDER OF COMPENSATION BENEFITS IN SETTLEMENT OF MALPRACTICE CLAIMS

"SEC. 1821. (a)(1)(A) In the case of a health care provider (as defined in paragraph (4)(D)) which—

"(i) is participating in an assigned claims plan under section 1826 and

"(ii) is potentially liable for a personal injury (as defined in paragraph (4)(A)) to an injured individual,

if the provider provides the individual not later than the date specified in subparagraph (B) with a written tender to pay compensation benefits with respect to such injury in accordance with this subpart, the individual and any other person shall (except as provided in paragraph (3)) be foreclosed from bringing any civil action described in paragraph (2) against such provider or other person joined under subsection (b) based on such personal injury.

"(B) The date referred to in subparagraph (A) is (i) in the case of a personal injury resulting from a stay as an inpatient in an institution, 180 days after the date of the patient's

discharge from the institution, or (ii) in the case of any other personal injury, 180 days after the date of the action or inaction giving rise to the personal injury, except that such date may be extended for up to an additional 60 days if the provider and the patient agree in writing to such extension.

"(2)(A) Except as provided in subparagraph (B), civil actions referred to in paragraph (1) include any civil action (whether brought in a Federal or State court) which could have been brought against a compensation obligor (as defined in subsection (d)(1)) with respect to recovery of damages relating to personal injury, whether based on (i) negligence or gross negligence, (ii) strict or absolute liability in tort, (iii) breach of express or implied warranty or contract, (iv) failure to discharge a duty to warn or instruct or to obtain consent, or (v) any other theory that is the basis for an award of damages for personal injury.

"(B) Civil actions referred to in subparagraph (1) do not include—

"(i) any action to recover for compensation benefits tendered under this subpart, or

"(ii) any action in the nature of a wrongful death action, but only in the case of such an action for losses accruing to survivors after the death of an injured individual and resulting from the death of the individual.

"(3) In no event shall a civil action be foreclosed under paragraph (1) against any party which intentionally caused or intended to cause injury, except that this paragraph shall not apply with respect to a personal injury unless the injured individual provides the provider making the tender with a notice not later than 90 days after the date the tender of compensation benefits was made.

"(4) As used in this subpart:

"(A) The terms 'injury' and 'personal injury' mean sickness or disease or bodily harm arising from provision of health care services provided pursuant to (or for which payment may be made under) this title, a State plan approved under title XIX, plans under sections 1079 and 1086 of title 10, United States Code (relating to the CHAMPUS program), section 613 of title 38, United States Code (relating to the CHAMPVA program), a health benefits plan pursuant to a contract with the Office of Personnel Management under chapter 89 of title 5, United States Code (relating to the Federal employees health benefits program), title 10 or title 38 of the United States Code (relating to the Department of Defense and the Veterans' Administration), or any other program established under Federal law.

"(B) The term 'injured individual' means an individual suffering injury in the course of health care provided by an entity.

"(C) A person intentionally causes or attempts to cause a personal injury when the person acts or fails to act for the purpose of causing injury or with knowledge that injury is substantially certain to follow; but a person does not intentionally cause or attempt to cause injury merely because the individual's act or failure to act is intentional or is done with the individual's realization only that it creates a grave risk of causing injury without the purpose of causing injury or if the act or omission is for the purpose of averting bodily harm to the individual or another person.

"(D) The term 'health care provider' means—

"(i) any institution described in subsection (e)(1), (f)(1), (g)(1), (j)(1) of section 1861 which meets the requirement of section 1861(e)(7),

"(ii) an agency or organization described in section 1861(o)(1) which meets the requirement of section 1861(o)(4),

"(iii) any health care professional described in section 1861(r), and

"(iv) a rural health clinic (as defined in section 1861(aa)(2)), a comprehensive outpatient re-

habilitation facility (as defined in section 1861(cc)(2)), and a hospice program (as defined in section 1861(dd)(2)).

"(b)(1)(A) A health care provider making a tender under subsection (a) may, by written notice to the person, join in the foreclosure provided under subsection (a) any person who is potentially liable, in whole or in part, for the personal injury and who may benefit from foreclosure of action against the person under subsection (a). Joinder under this subparagraph may only be by written notice to the party to be joined and such notice shall not be effective if provided later than the date the provider makes the tender under subsection (a).

"(B) Any person who would benefit from foreclosure of action against the person under subsection (a) with respect to a personal injury shall be joined in any tender made under subsection (a) with respect to that injury if the person requests such joinder by written notice to the provider making the tender under subsection (a) not later than the date the tender under subsection (a) is made.

"(2) By joinder under this subsection, a third party is deemed to have agreed to pay a share of (A) such compensation benefits and (B) the reasonable costs incurred by the provider in preparing and making such tender and paying compensation benefits. Any disagreement between such parties involved as to any party's share of the benefits and costs

or the amount of such costs shall be submitted to binding arbitration for determination and each party's share shall be based on the comparative fault of the parties (other than the injured individual) involved.

"(c)(1) Any party which has tendered compensation benefits with respect to an individual under subsection (a) or been joined in the tender under subsection (b) shall be subrogated to any rights of the individual against another person (other than against another party joined under subsection (b)) arising from or contributing to the personal injury and shall have a cause of action separate from that of the individual to the extent that (A) elements of damage compensated for by compensation benefits are recoverable and (B) the party has paid or becomes obligated to pay accrued or future compensation benefits.

"(2) In the case that a foreclosure from liability is effected under subsection (a), no right of subrogation, contribution, or indemnity shall exist against a compensation obligor other than the right of contribution among compensation obligors under subsection (b)(2), nor shall any provision of any contract be enforced that has the effect of limiting or excluding payment under that contract because of the existence or payment of compensation benefits under this subpart.

"(d) As used in this subpart:

"(1) The term 'compensation obligor' means, with respect to a personal injury, the health care provider that has obligated itself to pay compensation benefits under subsection (a) with respect to that injury and includes (A) any person that has been joined under subsection (b) with respect to that injury and (B) any other entity (including an insurance company) which is contractually responsible for payment of the obligations of a compensation obligor under this subpart.

"(2) The term 'initiating compensation obligor' means, with respect to a personal injury, the compensation obligor which (A) first tenders compensation benefits to the injured individual, or (B) agrees to serve as an initiating compensation obligor and has been designated as such by a majority of the compensation obligors for that injury for purposes of this subpart.

"AMOUNT OF, AND ADJUSTMENTS TO, COMPENSATION BENEFITS

"SEC. 1822. (a)(1) The amount of compensation benefits payable with respect to a personal injury is equal to the net economic loss (as defined in subsection (b)(1)) resulting from such injury, plus attorney's fees (as provided under subsection (c)).

"(b) For purposes of this subpart:

"(1) The term 'net economic loss' means—

"(A) economic detriment, consisting only of—

"(i) allowable expense (as defined in paragraph (2)(A)),

"(ii) work loss (as defined in paragraph (2)(B)), and

"(iii) replacement services loss (as defined in paragraph (2)(C)),

whether caused by pain and suffering or physical impairment, but not including noneconomic loss (as defined in paragraph (3)), less collateral benefits (as defined in paragraph (4)).

"(2)(A) The term 'allowable expense' means reasonable expenses incurred for products, services, and accommodations reasonably needed for medical care, training, and other remedial treatment and care of an injured individual, but includes expenses for rehabilitation treatment and occupational training only in accordance with subsection (d).

"(B) The term 'work loss' means 100 percent of the loss of income from work the injured individual would have performed if the individual had not been injured, reduced by any income from substitute work actually performed by the individual or by income the individual would have earned in available appropriate

substitute work the individual was capable of performing but unreasonably failed to undertake.

"(C) The term 'replacement services loss' means reasonable expenses incurred in obtaining ordinary and necessary services in lieu of those the injured individual would have performed, not for income but for the benefit of the individual or the individual's family, if the individual had not been injured.

"(3) The term 'noneconomic detriment' means pain, suffering, inconvenience, physical impairment, mental anguish, emotional pain and suffering, punitive or exemplary damages, and all other general (as opposed to special) damages, including loss of earning capacity and loss of any of the following which would have been provided by an injured individual to another: consortium, society, companionship, comfort, protection, marital care, attention, advice, counsel, training, guidance, and education. Such term does not include pecuniary loss caused by pain and suffering or by physical impairment.

"(4) The term 'collateral benefits' means all benefits and advantages received or entitled to be received (regardless of any right any other person has or is entitled to assert for recoupment through subrogation, trust agreement, lien, or otherwise) by an injured indi-

vidual or other person as reimbursement of loss because of personal injury, payable or required to be paid, under—

"(A) the laws of any State or the Federal government (other than through a claim for breach of an obligation or duty), or

"(B) any health or accident insurance, wage or salary continuation plan, or disability income insurance;

except that no benefits payable with respect to an injury under this title or under a State plan approved under title XIX shall be considered to be collateral benefits for purposes of this subparagraph.

"(c)(1) Compensation benefits shall include reasonable expenses incurred by the injured individual in collecting such benefits, including a reasonable attorney's fee. Such expenses may be offset from the amount of compensation benefits otherwise provided, if any significant part of a claim for compensation benefits is fraudulent or so excessive as to have no reasonable foundation.

"(2) A compensation obligor defending a claim for compensation benefits shall be allowed a reasonable attorney's fee, in addition to other reasonable expenses incurred, in defending such a claim or part thereof that is fraudulent or so excessive as to have no reasonable foundation. The fee or

expenses may be treated as an offset to any compensation benefits due. The compensation obligor may recover from the claimant any part of the fee or expenses not offset or otherwise paid.

"(d)(1) Allowable expenses under subsection (b)(2)(A) include expenses for a procedure or treatment for rehabilitation and rehabilitative occupational training if the procedure, treatment, or training is reasonable and appropriate for the particular case, the expenses are reasonable in relation to the probable rehabilitative effects and the compensation benefits otherwise payable, and it is likely to contribute substantially to rehabilitation, even though it will not enhance the injured individual's earning capacity.

"(2) Allowable expenses shall not include expenses described in paragraph (1) with respect to a procedure or treatment for rehabilitation or a course of rehabilitative occupational training which exceed $2,000 in any 30-day period unless the injured individual has provided the initiating compensation obligor with notice of such procedure, treatment, or course of training before expenses totaling $2,000 with respect to such procedure, treatment, or course of training during such period have been incurred.

"PAYMENT OF COMPENSATION BENEFITS

"SEC. 1823. (a)(1)(A) Compensation benefits shall be paid not later than 30 days after the date there is submitted

to the initiating compensation obligor reasonable proof of the fact and amount of net economic loss incurred, except that payment may be made, for expenses incurred over periods not exceeding 31 days, within 15 days after the end of the period. If reasonable proof is supplied as to only a portion of net economic loss, and the portion totals $100 or more, the compensation benefits with respect to that portion shall be paid without regard to the remainder of the net economic loss. An injured party to whom a tender of compensation benefits has been made under section 1821 shall be entitled to interest, at the annual rate of interest applied to judgments in the State in which the injury occurred, on such benefits not paid on a timely basis.

"(B) If there elapses a period of five years after a claim for payment of net economic loss incurred is last made with respect to a personal injury, the injured individual is no longer entitled to receive compensation benefits with respect to that injury.

"(2) A compensation obligor who rejects a claim for compensation benefits shall give to the claimant prompt written notice of the rejection and the reasons therefor.

"(3) Compensation benefits with respect to allowable expenses may be paid either to the injured individual or to the person supplying the products, services, or accommodations to the individual.

"(b) In lieu of payment therefor as a part of allowable expenses and with the consent of the injured individual, a health care provider may provide medical or rehabilitative services needed by the injured individual.

"(c)(1) Except as otherwise provided in this subsection or section 1822(c)(2), compensation benefits shall be paid without deduction or setoff.

"(2) An assignment or an agreement to assign any right to compensation benefits under this subpart for net economic loss accruing in the future is unenforceable except as to benefits for—

"(A) work loss to secure payment of alimony, maintenance, or child support; or

"(B) allowable expenses to the extent the benefits are for the cost of products, services, or accommodations provided or to be provided by the assignee.

"(3)(A) Compensation benefits for allowable expense are exempt from garnishment, attachment, execution, and any other process or claim, except upon a claim of a creditor who has provided products, services, or accommodations to the extent benefits are for allowable expense for those products, services, or accommodation.

"(B) Compensation benefits other than those for allowable expense are exempt from garnishment, attachment, execution, and any other process or claim to the extent that

wages or earnings are exempt under any applicable law exempting wages or earnings from process or claims.

"(4)(i) Except as provided in clause (iii), a claim for compensation benefits shall be paid without deduction or offset for collateral benefits, if the collateral benefits have not been paid to the injured individual before the incurring of expenses included in net economic loss.

"(ii) The compensation obligor is entitled to reimbursement from the person obligated to make the payments or from the person who actually receives the payments.

"(iii) A compensation obligor may offset amounts it is entitled to recover under clause (ii) against any compensation benefits otherwise due.

"(d)(1) A party making payment of compensation benefits under this subpart may bring an action against a person to recover compensation benefits paid because of an intentional misrepresentation of a material fact by that person upon which the party relied, except that such an action may not be brought against the injured individual unless the injured individual made or had knowledge of the making of the misrepresentation.

"(2) If such party secures judgment in an action under paragraph (1), the party may offset amounts it is entitled to recover under such judgment against any compensation benefits otherwise due.

"REQUIRING DISCLOSURE OF FACTS ABOUT, AND MENTAL AND PHYSICAL EXAMINATION OF, INJURED INDIVIDUALS

"SEC. 1824. (a)(1) Upon request of an injured individual or compensation obligor, information relevant to payment of compensation benefits shall be disclosed as follows:

"(A) The injured individual shall furnish evidence of the individual's earnings, if self-employed.

"(B) An employer of the individual shall furnish a statement of the work record and earnings of an injured individual who is or was an employee of the employer, for the period specified by the injured individual or obligor making the request, which may include a reasonable period before, and the entire period after, the injury.

"(C) The injured individual shall deliver to the compensation obligor upon request a copy of every written report, not otherwise available to the compensation obligor, previously or thereafter made, available to the individual, concerning any medical treatment or examination of the injured individual and the names and addresses of hospitals, physicians, and other persons and entities, examining, diagnosing, treating, or providing accommodations to the individual in regard to the injury or to a relevant past injury, and the in-

jured individual shall authorize the compensation obligor to inspect and copy all relevant records made by such persons and entities.

"(D) A hospital, physician, or other person or entity examining, diagnosing, testing, or providing accommodations to an injured individual in connection with a condition alleged to be connected with an injury upon which a claim for compensation benefits is based, upon authorization of the injured individual, shall furnish a written report of the history, condition, diagnosis, medical tests, treatment, and dates and cost of treatment of the injured individual in connection with that condition or any previous or other condition which may be relevant to assessing such condition, and permit inspection and copying of all records and reports as to the history, condition, treatment, and dates and cost of treatment.

Any person (other than the injured individual or a compensation obligor) providing information under this paragraph may charge the person requesting the information for the reasonable cost of providing it.

"(2) In case of dispute as to the right of an injured individual or compensation obligor to discover information required to be disclosed under this subsection, the individual or obligor may petition a court having jurisdiction over the

matter for an order for discovery, including the right to take written or oral depositions. Upon notice to all persons having an interest, the order may be made for good cause shown. It shall specify the time, place, manner, conditions, and scope of the discovery. To protect against oppression, the court may enter an order refusing discovery or specifying conditions of discovery and directing payment of costs and expenses of the proceeding, including reasonable attorney's fees.

"(b)(1) If the mental or physical condition of an injured individual is material and relevant to compensation benefits, a compensation obligor may petition a court having jurisdiction over the matter for an order directing the individual to submit to a mental or physical examination by a physician. Upon notice to the individual to be examined and all persons having an interest, the court may make the order for good cause shown. The order shall specify the time, place, manner, conditions, scope of the examination, and the physician by whom it is to be made.

"(2) If requested by the individual examined, a compensation obligor causing a mental or physical examination to be made shall deliver to the individual examined a copy of the written report of the examining physician, and reports of earlier examinations of the same condition. By requesting and obtaining a report of the examination ordered or by taking the deposition of the physician, the individual examined

waives any privilege the individual may have, in relation to the claim for compensation benefits, regarding the testimony of every other person who has examined or may thereafter examine the individual respecting the same condition. This subsection does not preclude discovery of a report of an examining physician, taking a deposition of the physician, or other discovery procedures in accordance with any rule of court or other provision of law. This paragraph applies to examinations made by agreement of the individual examined and a compensation obligor, unless the agreement provides otherwise.

"(3) If any individual refuses to comply with an order entered under this subsection, the court may make any just order as to the refusal, but may not find an individual in contempt for failure to submit to a mental or physical examination.

"(c) If a health care provider tenders compensation benefits with respect to an injured individual under this subpart and there is a dispute between the compensation obligors and the injured individual respecting the determination of the amount of the compensation benefits owing, except as otherwise provided under this subpart, the initiating compensation obligor or the individual may apply to a court with appropriate jurisdiction for a declaration as to the amount of the compensation benefits owed.

"LUMP SUM AND INSTALLMENT SETTLEMENTS AND DECLARATIONS OF BENEFITS

"SEC. 1825. (a) An obligation to pay compensation benefits may be discharged initially or at any time thereafter by a settlement or lump sum payment, except that no such discharge shall be made with respect to an injury with a current value of net economic loss exceeding $5,000 unless a court having jurisdiction over the matter determines that the settlement is fair to the injured individual. A settlement agreement may also provide that the compensation obligor shall pay the reasonable cost of appropriate medical treatment or procedures, with reference to a specified condition, to be performed in the future.

"(b)(1) In an action for payment of unpaid compensation benefits, a judgment may be entered for compensation benefits, other than allowable expense, that would accrue after the date of the award. The court may enter a judgment declaring that the compensation obligor is liable for the reasonable cost of appropriate medical treatment or procedures, with reference to a specified condition, to be performed in the future if it is ascertainable or foreseable that treatment will be required as a result of the injury for which the claim is made.

"(2) A judgment for compensation benefits, other than with respect to allowable expenses, that will accrue thereaf-

ter may be entered only for a period as to which the court can reasonably determine future net economic loss.

"(3) If the injured individual notifies the initiating compensation obligor of a proposed specified procedure or treatment for rehabilitation or specified course of rehabiliation occupational training the expenses of which are an allowable expense and the compensation obligor does not promptly agree to such characterization, the injured individual may move the court in an action to adjudicate the individual's claim, or, if no action is pending, bring an action in a court having jurisdiction over the matter for a determination respecting whether or not such expenses are allowable expenses for which compensation benefits are payable. The initiating compensation obligor may move the court in an action to adjudicate the injured individual's claim, or, if no action is pending, bring an action in a court having jurisdiction over the matter for such a determination as to whether or not expenses for such a procedure, treatment, or course or training which an injured individual has undertaken or proposes to undertake are allowable expenses for which compensation benefits are payable. This subsection does not preclude an action by the initiating compensation obligor or the injured individual for declaratory relief under any other applicable law, nor an action by the injured individual to recover compensation benefits.

"(4) If an injured individual unreasonably fails, either directly or through one legally empowered to act on the individual's behalf, to obtain medical care, rehabilitation, rehabilitative occupational training, or other medical treatment which is reasonable and appropriate, the initiating compensation obligor may move the court in an action to adjudicate the injured individual's claim, or, if no action is pending, may bring an action in a court having jurisdiction over the matter for a determination that future benefits will be reduced or terminated to an amount equal to benefits that in reasonable probability would be due if the injured individual had submitted to the procedure, treatment, or training, and for other reasonable order. In determining whether an injured individual has reasonable ground for refusal to undertake the procedure, treatment, or training, the court shall consider all relevant factors, including the risks to the injured individual, the extent of the probable benefit, the place where the procedure, treatment, or training is offered, the extent to which the procedure, treatment, or training is recognized as standard and customary, and whether the restriction of this paragraph because of the individual's refusal would abridge the individual's right to the free exercise of religion.

"(c)(1) A settlement agreement or judgment under this section may be modified as to amounts to be paid in the future upon a finding that a material and substantial change

of circumstances has occurred after the date the agreement or judgment was made, or that there is newly discovered evidence concerning the injured individual's physical condition, loss, or rehabilitation, which would not have been known previously or discovered in the exercise of reasonable diligence prior to such agreement or judgment.

"(2) The court may make appropriate orders concerning the safeguarding and disposing of the proceeds of settlement agreements and funds collected under judgments under this section.

"(3) A settlement agreement or judgment for compensation benefits may be set aside if it is found to have been procured by fraud.

"ASSIGNED CLAIMS PLAN

"SEC. 1826. (a) In order to participate in the alternative liability program under this subpart, a health care provider must participate, directly or through an insurance company which has agreed to be the compensation obligor with respect to that provider, in an assigned claims plan which meets the requirements of this section in order to insure the payment of compensation benefits by compensation obligors.

"(b)(1) Entities (including insurance companies) in a State may organize and maintain, subject to approval and regulation by the regulator of insurance therein, an assigned

claims plan and adopt rules for its operation (including designation of assignees) consistent with this section.

"(2) If such a plan is not established or maintained in a State, whether organized by such entities or otherwise under State law, the Secretary shall organize and maintain an assigned claims plan for the State meeting the requirements of this section for purposes of this subpart. The Secretary may not establish an assigned claims plan under this paragraph with respect to health care providers located in a State unless the Secretary determines that no plan under paragraph (1) has been established in the State and the Secretary has provided the State with notice providing the State at least six months in which to establish such a plan.

"(3) Each assigned claims plan shall provide for assessment of costs on a fair and equitable basis consistent with this subpart and providing for assignment of claims in accordance with subsection (c). An assigned claims plan may not permit an entity covered under the plan to withdraw from the plan retrospectively.

"(c)(1) An injured individual entitled to compensation benefits from a compensation obligor pursuant to this subpart may obtain them through the assigned claims plan established pursuant to this section if the initiating compensation obligor obligated therefor claims that it is or is financially unable to fulfill its obligation.

"(2) Where an assigned claims plan finds that a compensation obligor which is associated with such plan reasonably claims that it is or is financially unable to pay the compensation benefits it owes, the assigned claims plan shall promptly assign the claims to a member or members of the plan and notify the individual or individuals entitled to receive such benefits of the identity and address of the assignee or assignees. Claims shall be assigned so as to minimize inconvenience to injured individuals. Any such assignee shall have all rights and obligations as if it had lawfully obligated itself to pay such compensation benefits and the plan and assignee may seek payment (including interest) from the compensation obligor or its successor of 120 percent of the costs and expenses incurred in fulfilling the obligor's obligations.

"(d) If an obligation qualifies for assignment under this section, the assigned claims plan or any compensation obligor to whom the claim is assigned is subrogated to all rights of the injured individual against any compensation obligor, its successor in interest or substitute, legally obligated to provide compensation benefits to the injured individual, for compensation benefits provided by the assignee.

"EFFECTIVE DATE AND APPLICATION OF ALTERNATIVE STATE MEDICAL LIABILITY LAWS

"SEC. 1827. (a) Notwithstanding any other provision of this subpart, the preceding provisions of this subpart shall not apply to any personal injury occurring—

"(1) before January 1, 1987, or

"(2) in a State which has in effect an alternative medical liability law (hereinafter in this section referred to as the 'State law') which the Secretary of Health and Human Services determines substantially meets the requirements of this section.

"(b)(1)(A) The State law must provide that in the case of a health care provider that is potentially liable for a personal injury (as defined in paragraph (4)(A)) to an injured individual, if the provider provides the individual not later than the date specified in subparagraph (B) with a written tender to pay compensation benefits with respect to such injury in accordance with the law, the individual and any other person shall (except as provided in paragraph (3)) be foreclosed from bringing any civil action described in paragraph (2) against such provider or other person joined under subsection (c)(1) based on such personal injury.

"(B) The date referred to in subparagraph (A) is (i) in the case of a personal injury resulting from a stay as an inpatient in an institution, 180 days after the date of the patient's

discharge from the institution, or (ii) in the case of any other personal injury, 180 days after the date of the action or inaction giving rise to the personal injury.

"(2)(A) Except as provided in subparagraph (B), civil actions referred to in paragraph (1) include any civil action (whether brought in a Federal or State court) which could have been brought against a compensation obligor (as defined in paragraph (4)(D)) with respect to recovery of damages relating to personal injury, whether based on (i) negligence or gross negligence, (ii) strict or absolute liability in tort, (iii) breach of express or implied warranty or contract, (iv) failure to discharge a duty to warn or instruct or to obtain consent, or (v) any other theory that is the basis for an award of damages for personal injury.

"(B) Civil actions referred to in subparagraph (1) do not include—

"(i) any action to recover for compensation benefits tendered under the law, or

"(ii) any action in the nature of a wrongful death action, but only in the case of such an action for losses accruing to survivors after the death of an injured individual and resulting from the death of the individual.

"(3) The State law shall not foreclose a civil action under paragraph (1) against any party which intentionally caused or intended to cause injury, except that this paragraph

shall not apply with respect to a personal injury unless the injured individual provides the provider making the tender with a notice of the application of this paragraph not later than 90 days after the date the tender of compensation benefits was made.

"(4) As used in this section:

"(A) The terms 'injury' and 'personal injury' mean sickness or disease or bodily harm arising from provision of health care services.

"(B) The term 'injured individual' means an individual suffering injury in the course of care provided by a health care provider.

"(C) A person intentionally causes or attempts to cause a personal injury when the person acts or fails to act for the purpose of causing injury or with knowledge that injury is substantially certain to follow; but a person does not intentionally cause or attempt to cause injury merely because the individual's act or failure to act is intentional or is done with the individual's realization only that it creates a grave risk of causing injury without the purpose of causing injury or if the act or omission is for the purpose of averting bodily harm to the individual or another person.

"(D) The term 'compensation obligor' means, with respect to a personal injury, the health care provider

that has obligated itself to pay compensation benefits under paragraph (1) with respect to that injury and includes (i) any person that has been joined under subsection (c)(1) with respect to that injury and (ii) any other entity (including an insurance company) which is contractually responsible for payment of the obligations of a compensation obligor under the State law.

"(c)(1)(A) The State law shall provide that a health care provider making a tender under subsection (b) may, by providing timely written notice to the person, join in the foreclosure provided under subsection (a) any person who is potentially liable, in whole or in part, for the personal injury and who may benefit from foreclosure of action against the person under subsection (a), and any such person who would benefit from such foreclosure shall be joined in any tender made under subsection (a) if the person requests such joinder by timely written notice to the health care provider making the tender under subsection (a).

"(B) By joinder under this paragraph, a third party is deemed to have agreed to pay a share of (i) such compensation benefits and (ii) the reasonable costs incurred by the health care provider in preparing and making such tender and paying compensation benefits. Any disagreement between such parties involved as to any party's share of the benefits and costs or the amount of such costs shall be submitted to

binding arbitration for determination and each party's share shall be based on the comparative fault of the parties (other than the injured individual) involved.

"(2)(A) The State law shall provide that any party which has tendered compensation benefits with respect to an individual under subsection (a) or been joined in the tender under paragraph (1) shall be subrogated to any rights of the individual against another person (other than against another party joined under paragraph (1) arising from or contributing to the personal injury and shall have a cause of action separate from that of the individual to the extent that (i) elements of damage compensated for by compensation benefits are recoverable and (ii) the party has paid or becomes obligated to pay accrued or future compensation benefits.

"(B) The State law shall provide that in the case that a foreclosure from liability is effected under subsection (a), no right of subrogation, contribution, or indemnity shall exist against a compensation obligor other than the right of contribution among compensation obligors under paragraph (1)(B), nor shall any provision of any contract be enforced that has the effect of limiting or excluding payment under that contract because of the existence or payment of compensation benefits under the law.

"(d)(1) The amount of compensation benefits payable with respect to a personal injury is equal to the net economic

loss (as defined in paragraph (2)) resulting from such injury, plus attorney's fees (as provided under paragraph (3)).

"(2)(A) For purposes of this section, the term 'net economic loss' means—

"(i) economic detriment, consisting only of—

"(I) reasonable expenses incurred for products, services, and accommodations reasonably needed for medical care, training, and other remedial treatment and care of an injured individual, but need include only such expenses for rehabilitation treatment and occupational training as the State law may provide consistent with paragraph (4),

"(II) the loss of income from work the injured individual would have performed if the individual had not been injured, reduced by any income from substitute work actually performed by the individual or by income the individual would have earned in available appropriate substitute work the individual was capable of performing but unreasonably failed to undertake, and

"(III) reasonable expenses incurred in obtaining ordinary and necessary services in lieu of those the injured individual would have performed, not for income but for the benefit of the

individual or the individual's family, if the individual had not been injured,

whether caused by pain and suffering or physical impairment, but not including noneconomic loss (as defined in subparagraph (B)), less collateral benefits (as defined in subparagraph (C)).

"(B) As used in subparagraph (A), the term 'noneconomic detriment' means pain, suffering, inconvenience, physical impairment, mental anguish, emotional pain and suffering, punitive or exemplary damages, and all other general (as opposed to special) damages, including loss of earning capacity and loss of any of the following which would have been provided by an injured individual to another: consortium, society, companionship, comfort, protection, marital care, attention, advice, counsel, training, guidance, and education. Such term does not include pecuniary loss caused by pain and suffering or by physical impairment.

"(C) As used in this section, the term 'collateral benefits' means all benefits and advantages received or entitled to be received (regardless of any right any other person has or is entitled to assert for recoupment through subrogation, trust agreement, lien, or otherwise) by an injured individual or other person as reimbursement of loss because of personal injury, payable or required to be paid, under—

"(A) the laws of any State or the Federal government (other than through a claim for breach of an obligation or duty), or

"(B) any health or accident insurance, wage or salary continuation plan, or disability income insurance; except that no benefits payable with respect to an injury under this title or under a State plan approved under title XIX shall be considered to be collateral benefits for purposes of this subparagraph.

"(3)(A) Compensation benefits shall include reasonable expenses incurred by the injured individual in collecting such benefits, including a reasonable attorney's fee. Such expenses may be offset from the amount of compensation benefits otherwise provided, if any significant part of a claim for compensation benefits is fraudulent or so excessive as to have no reasonable foundation.

"(B) The State law shall provide that a compensation obligor defending a claim for compensation benefits shall be allowed a reasonable attorney's fee, in addition to other reasonable expenses incurred, in defending such a claim or part thereof that is fraudulent or so excessive as to have no reasonable foundation. The fee or expenses may be treated as an offset to any compensation benefits due. The compensation obligor may recover from the claimant any part of the fee or expenses not offset or otherwise paid.

"(4) The State law shall provide for expenses under paragraph (2)(A)(i)(I) for a procedure or treatment for rehabilitation and rehabilitative occupational training if the procedure, treatment, or training is reasonable and appropriate for the particular case, the expenses are reasonable in relation to the probable rehabilitative effects and the compensation benefits otherwise payable, and it is likely to contribute substantially to rehabilitation, even though it will not enhance the injured individual's earning capacity.

"(d)(1)(A) The State law shall provide that compensation benefits described in this section shall be paid on a timely basis and generally not later than 30 days after the date there is submitted reasonable proof of the fact and amount of net economic loss incurred, with interest to the extent to which the benefits are not paid on a timely basis.

"(B) The State law shall provide that if there elapses a period of five years after a claim for payment of net economic loss incurred is last made with respect to a personal injury, the injured individual is no longer entitled to receive compensation benefits with respect to that injury.

"(2) The State law may permit the payment of compensation benefits either to the injured individual or to the person supplying the products, services, or accommodations to the individual, and, in lieu of payment therefor as a part of compensation benefits and with the consent of the injured

individual, a health care provider may provide medical or rehabilitative services needed by the injured individual.

"(3) The State law shall provide that a party making payment of compensation benefits under the law may bring an action against a person to recover compensation benefits paid because of an intentional misrepresentation of a material fact by that person upon which the party relied, except that such an action may not be brought against the injured individual unless the injured individual made or had knowledge of the making of the misrepresentation.

"(4) The State law shall make appropriate provision for requiring—

"(A) the furnishing of information necessary for compensation obligors to determine the amount of compensation benefits to be paid with respect to an injured individual, including compulsory process where there has been a failure to properly disclose such information, and

"(B) for an injured individual to submit to a mental or physical examination by a physician if the mental or physical condition of the injured individual is material and relevant to compensation benefits.

"(e)(1)(A) The State law shall provide for a process whereby an obligation to pay compensation benefits may be discharged initially or at any time thereafter by a settlement

or lump sum payment, except that no such discharge shall be permitted with respect to an injury with a current value of net economic loss exceeding $5,000 unless a court having jurisdiction over the matter determines that the settlement is fair to the injured individual.

"(B) A settlement agreement may also provide that the compensation obligor shall pay the reasonable cost of appropriate medical treatment or procedures, with reference to a specified condition, to be performed in the future.

"(C) Such a settlement agreement may be made subject to subsequent modification upon a finding that a material and substantial change of circumstances has occurred after the date the agreement was made, or that there is newly discovered evidence concerning the injured individual's physical condition, loss, or rehabilitation, which would not have been known previously or discovered in the exercise of reasonable diligence prior to such agreement.

"(D) A settlement agreement or judgment for compensation benefits may be set aside if it is found to have been procured by fraud.

"(2) The State law shall provide for an appropriate process for the declaration of the amount of compensation benefits owing or to be due an individual and for a reduction in compensation benefits where the injured individual unreasonably fails, either directly or through one legally empow-

ered to act on the individual's behalf, to obtain medical care, rehabilitation, rehabilitative occupational training, or other medical treatment which is reasonable and appropriate.

"(f)(1) The State law shall require each entity providing health care services in the State to participate in an assigned claims plan under which the plan will assure that, if the entity or other compensation obligor is unable to make payment of compensation benefits in accordance with the law, the plan will assume responsibility for such payments or provide for assignment of responsibility with respect to such payments. Any such plan or assignee shall have all rights and obligations as if it had lawfully obligated itself to pay such compensation benefits and the plan and assignee may seek payment (including interest) from the compensation obligor or its successor of at least the costs and expenses incurred in fulfilling the obligor's obligations.

"(2) If an obligation qualifies for assignment under this subsection, the plan or assignee shall be subrogated to all rights of the injured individual against any compensation obligor, its successor in interest or substitute, legally obligated to provide compensation benefits to the injured individual, for compensation benefits provided by the assignee.".

(b) The first sentence of section 1862(b)(1) of the Social Security Act (42 U.S.C. 1395y(b)(1)) is amended by inserting before the period at the end the following: "or as compensa-

tion benefits under subpart II of part A or under an alternative State liability law meeting the requirements of section 1827".

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ALTERNATIVE MEDICAL LIABILITY ACT (H.R. 5400)

SUMMARY OF MAJOR PROVISIONS

FEDERAL SYSTEM

TENDER OF COMPENSATION BENEFITS IN SETTLEMENT OF MALPRACTICE CLAIMS

The federal system would be applicable to hospitals, physicians and other health care providers potentially liable for a personal injury arising from the provision of health care services under medicare, medicaid, CHAMPUS, CHAMPVA, or any other federal health program. Under this bill, such providers may offer the injured individual with a written tender to pay compensation benefits by a specified date. If the provider tenders an offer, within the specified time, the injured individual would be foreclosed from bringing any civil action based on such personal injury. For cases resulting from a stay as an inpatient, the tender must be offered within 180 days after discharge, or in the case of any other personal injury, 180 days after the action or inaction giving rise to the personal injury. An additional 60 days would be allowed if both parties agreed.

The types of civil actions which would be precluded would be any action with respect to recovery of damages based on negligence, strict or absolute liability in tort, breach of express or implied warranty, failure to discharge a duty to warn, instruct or obtain consent, or any other theory that is the basis for an award of damages for personal injury. Civil actions not precluded would be actions to recover the compensation benefits tendered or certain actions in the nature of wrongful death (for losses accruing to survivors). In addition, civil actions would not be foreclosed against any party who intentionally caused or intended to cause injury. However, an action based on intentional injury would be foreclosed if the injured person did not notify the provider within 90 days after the original tender.

A health care provider making a tender would be permitted to join in the foreclosure any person who is potentially liable for the personal injury and who may benefit from such foreclosure against the injured party. In addition, any person who would benefit from foreclosure may request to be joined in the tender. The health care provider which has obligated itself to pay compensation benefits, and third-parties joined, would be known as the compensation obligor(s). Joinder could be made only by written notice and would not be effective if provided later than the date on which tender is made by the provider. The third-parties joined would be required to pay a share of the

compensation benefits and the reasonable costs incurred by the health care provider in making the tender. Any disagreement about the share would be submitted to binding arbitration and be based on comparative fault of the parties.

AMOUNTS OF, AND ADJUSTMENTS TO, COMPENSATION BENEFITS

The amount of compensation benefits payable would equal the net economic loss resulting from the injury. Net economic loss would include: (1) 100 percent of the loss of income from work, with an offset for income earned from work actually performed or which could have been earned from work the individual unreasonably failed to undertake; (2) replacement services loss, including reasonable expenses incurred in obtaining ordinary and necessary services in lieu of those the individual would have performed for himself or his family; (3) reasonable expenses incurred for medical care, training and other remedial treatment, including reasonable rehabilitation treatment and occupational training costs and (4) reasonable expenses incurred in collecting benefits, including attorneys' fees.

Noneconomic detriment would not be recoverable. Noneconomic detriment would include loss of earning capacity, pain, suffering, physical impairment, mental anguish, loss of consortium, companionship, marital care and other general damages.

PAYMENT OF COMPENSATION BENEFITS

Compensation benefits would be payable not later than 30 days after the injured party submitted reasonable proof of the fact and the amount of economic loss. Payment would be permitted to be made for expenses incurred over periods not exceeding 31 days if payment is made within 15 days after the end of such period. Where the claim for payment of an injured individual is rejected by the compensation obligor, prompt written reasons must be given for the rejection.

The injured party would be entitled to interest on benefits not paid on a timely basis in accordance with State law. The injured party would no longer be entitled to compensation benefits with respect to such injury if a period of five years elapses after a claim for payment of net economic loss is last made.

Compensation benefits could be paid either to the injured party or directly to the person supplying the products or services to the individual. The health care provider would be permitted, if the injured individual consents, to provide the necessary medical and/or rehabilitation services to the injured individual, in lieu of payment.

A party making payment of compensation benefits under this provision would be permitted to bring an action against an individual to recover compensation benefits paid as a result of an intentional misrepresentation of a material fact.

REQUIRING DISCLOSURES OF FACTS ABOUT, AND MENTAL AND PHYSICAL EXAMINATION OF, INJURED INDIVIDUALS

The injured individual or compensation obligor would be permitted to request and have disclosed the injured individual's earning record, if self-employed or, the statement of the work record and earnings of the injured individual who is or was an employee. In addition, if the compensation obligor requests, the injured individual would be required to disclose every written report available to the individual concerning medical treatment or examination and the names and addresses of the examining or treating health care providers. Upon authorization of the injured individual, any health care provider who examines or tests the individual with respect to the alleged injury would be required to furnish a written report of the history, condition, diagnosis, medical tests, treatment, dates and cost of such services provided to the injured party. A court may be petitioned by either party for discovery of information.

If the mental or physical condition of an injured party is material and relevant to compensation benefits, the compensation obligor would be permitted to petition a court for an order directing the individual to submit to a mental or physical examination. If the court orders an examination, it would be required to specify in its order the scope of the examination and the physician by whom the examination is to be made.

If requested by the injured party examined, the compensation obligor would be required to deliver to the individual a copy of the examining physician's written report. By so requesting or by taking the deposition of the physician, the injured individual would waive any privilege that he or she may have regarding the testimony of every other person who has, or may examine the individual.

If there is a dispute regarding the amount of compensation benefits owing, either party would be permitted to apply to a court for a declaration of such amount.

LUMP SUM AND INSTALLMENT SETTLEMENT AND DECLARATION OF BENEFITS

An obligation to pay compensation benefits would be discharged by a settlement or lump sum payment. Settlements with a net economic loss exceeding $5,000 must be determined by a court to be fair to the injured party before the compensation obligor would be discharged from its liability.

A settlement agreement may provide that the obligor will pay the reasonable costs of medical treatment to be performed in the future. In an action for unpaid compensation benefits, the court may enter a judgment declaring the obligor liable for the reasonable costs of medical treatment in the future. Either party may bring court action with respect to rehabilitation treatment expenses. If an injured party unreasonably refuses to submit to medical or other treatment, the obligor may bring court action to adjudicate the amount of the claim.

A settlement or judgment would be subject to future modification upon a finding that a material and substantial change of circumstances had occurred or that there was new evidence of the individual's physical condition or loss, which would not have been previously known in the exercise of reasonable diligence.

ASSIGNED CLAIMS PLAN

In order to participate in the alternative liability program, a health care provider would be required to participate, directly or through an insurance company which has agreed to be the compensation obligor with respect to that provider, in an assigned claims plan. If such a plan is not established in the State, the Secretary (after 6 months notice to the State) would be required to organize and maintain an assigned claims plan.

An injured individual entitled to compensation benefits would be permitted to obtain them through the assigned claims plan if the initiating compensation obligor is financially unable to fulfill its obligation. In this circumstance, the plan would be required to assign the claim on a fair and equitable basis to member(s) of the plan and to notify the injured individual of such assignment. Any such assignee would have all the rights and obligations as if it had been lawfully obligated to pay such compensation benefit.

The assignee would be permitted to seek payment, including interest from the compensation obligor or its successor, of 120 percent of the cost and expenses in fulfilling the obligor's obligation.

EFFECTIVE DATE AND APPLICATION OF ALTERNATIVE STATE MEDICAL LIABILITY LAWS

The Federal provisions of this bill apply beginning January 1, 1987, unless a State has an alternative medical liability law in effect by that date.

The State plan would follow substantially the same criteria as the Federal system, except that it would be applicable to any individual suffering an injury in the course of care provided by a health care provider (not just to individuals receiving services provided under a Federal health care program).

Chairman JACOBS. We convene the meeting of the Ways and Means Health Subcommittee. The hearing we have this morning is on the bill H.R. 5400, the Alternative Medical Liability Act, introduced and authored by our colleague Henson Moore.

Our first witness today is the most honorable—I see I am upstaging Mr. Gephardt. Do you think you should take precedence over the ranking member of this subcommittee?

Mr. GEPHARDT. No, clearly not.

Chairman JACOBS. I didn't think so.

The Chair recognizes Mr. Moore for an opening statement.

Mr. MOORE. Thank you, Mr. Chairman.

Certainly I thank my colleague. Mr. Gephardt and I coauthored and cosponsored this bill. I want to thank you, Mr. Chairman, for providing time in a very busy schedule to have this hearing on this subject which is something I think needs to be aired, needs to be looked into. We have introduced this bill in an effort to bring public attention to the problems our current system has for compensating victims of medical malpractice. The two of us have come to the conclusion that the overall cost of health care will not be brought under control unless we sooner or later address the growing problem of increasing malpractice settlement costs, malpractice insurance premiums, and especially the cost of defensive medicine.

These costs are passed on to the consumers. Malpractice costs are one of the reasons overall health care costs are going up so greatly. The Government, which is the purchaser of 40 percent of the health care consumers of this country, is also paying that price. The threat of malpractice suits adversely affects the health care system today. It affects the conduct of hospitals, physicians, and the patients and is an unproductive force in the provision of health care in our country.

There continues to be an increasing number of claims, the cost of defensive medicine contributes $15 billion to the cost of services alone, liability insurance premiums approached $3 billion last year and are still increasing. Clearly that is a problem worthy of the attention of this subcommittee.

So I appreciate the opportunity to focus on this problem, Mr. Chairman. I am hopeful today that this hearing will begin to bring light on the many problems faced by both consumers and providers of health care through broad representation from the health care community, consumers, business, and the legal community here to discuss this today. I compliment our witnesses on taking the time to prepare and be here this morning to testify on this complex problem and to bring out both the good and bad points this legislation may embody.

In conclusion, Mr. Chairman, I would like to say we have spent more than 1 year in the drafting of this bill, working as best we could with all aspects of the problem with groups involved. We have come to the point we don't think further study on our part will be that much more beneficial. Therefore, we thought it was time to introduce a bill to have a hearing on the bill and to let the people who know more about this subject than the two of us come in and testify so that we might have a better product to be considered more seriously perhaps with a chance of passage in the next Congress.

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So, Mr. Chairman, I do thank you for the opportunity for us to begin what may be a long but I hope a very fruitful road in discussing the problem of medical malpractice.

Thank you, Mr. Chairman.

Chairman JACOBS. Thank you, Mr. Moore.

We will be pleased to hear from Congressman Gephardt now.

STATEMENT OF HON. RICHARD A. GEPHARDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. GEPHARDT. Thank you, Mr. Chairman, and Mr. Moore, I appreciate the subcommittee having this hearing today in a busy schedule time on what I think is one of the most important issues facing us in the whole puzzle of health care costs which you should know are going up at much faster rates than the rate of inflation over the last 10 years at least and probably longer.

I want to first state the primary reason that we are interested in this issue are from the standpoint of the cost equation in the health care system, and from the fairness and effectiveness of the present malpractice system. We have come at this issue not from a special interest viewpoint. We are not trying to address this issue to help one group over another. We come at it from the point of view of trying to make the system work better, of fairly dealing with patients and consumers in the health care system, and from the overall cost of the system and ability of our society to adequately pay for our health care system.

As you both know and as is generally known, health care costs, and the problem of medical malpractice costs are getting worse. They have a negative impact on our health care system that goes beyond the financial costs. That is the bad news and there is plenty of it.

But there is also a bit of good news. I think it is embodied in the legislation we are talking about today. I think we believe that we have come up with a solution or at least the beginnings of a solution. It won't end medical malpractice but it will make the recovery system cheaper, more rational, and, I believe, fairer.

That would benefit all patients and providers including the great majority who have no direct contact with the medical malpractice problem at all.

Americans are now spending more than $320 billion a year on health care. That is a medical bill of nearly $1 billion a day and it adds up to more than 10 percent of our gross national product.

Malpractice is a significant part of our national medical bill. Each year more suits are filed. And each year we hear of new gigantic settlements that break previous records. How much the patient actually benefits from this trend is questionable, though, since only $1 of every $3 awarded ever finds its way to the patient at all. Some suggest that malpractice is a transfer program that shifts money from doctors to lawyers when they hear about how much money is diverted into the legal process.

Last year, American doctors paid about $1.7 billion for malpractice insurance. That is 17 percent more than they paid the year before. Every time you visit your doctor the bill is inflated by more than $3 to pay his malpractice bill. Hospitals have the same prob-

lem. Their room rates are increased by about $5 a day to cover malpractice protection. There is no evidence that things are going to get better.

They may be getting worse. Doctors feel the need for more protection as the size of awards grow. More than 50 percent of physicians now have insurance that will pay a million dollars or more for a single claim.

This results in staggering premiums. Some neurosurgeons now pay more than $40,000 a year for coverage. Some obstetricians pay more than $50,000.

These are extreme. But 2 years ago the average physician malpractice insurance premium was $5,800. In the past decade, such premiums have more than doubled.

Some doctors simply cannot afford them and have chosen to limit their practices instead. A survey of obstetricians found that 20 percent had cut back on high-risk care and that 9 percent had simply stopped delivering babies entirely. I don't think that is a healthy sign.

We now spend a total of $35 billion on malpractice when all the costs are considered. A good part of that comes from defensive medicine that is practiced solely to provide legal protection. This practice is so expensive that it threatens to undermine all our cost containment efforts.

During the last decade, malpractice premiums increased by 131 percent. At that rate, we will never get medical costs under control. We simply cannot afford to allow that trend to continue.

That is the problem as I see it. Now I would like to turn to our proposed solution. When Henson Moore and I first reviewed the situation, we were offended by several features of the status quo. There was no rational relationship between the problem and the settlement. One patient would win a million dollars. Another patient, who had the same problem, but a different lawyer or a less sympathetic jury, would come away with nothing. When the patient did prevail, he or she didn't get much of the money.

Meanwhile, doctors and hospitals were changing their style of medicine. The new defensive mode was costing a lot of money, but yielding no improvement in health care. From the patient's perspective, this money was simply wasted.

Our courts were swamped. Providers and insurance companies realized that they could often prevail by simply playing a waiting game. Prompt settlements became unusual. Patients in pain began by having a complaint against our health care system and ended by hating the legal system instead. All in all, we didn't see a very pretty picture.

We wanted to come up with a plan that offered people with real problems settlements that were both fast and fair. Our act begins by encouraging the States to make reforms in this direction for all patients. If they fail to act, the Alternative Medical Liability Act will be imposed on a State to apply to all patients whose care is paid for by the Federal Government.

Under our plan, a patient with a problem can file a complaint to recover his economic losses. That would include the additional medical care that was required, his loss of income and his lawyer's fees. It would not include pain and suffering.

The provider involved—physician, hospital or both—would then have 6 months to settle the claim for economic loss. If such a settlement was offered, the patient would lose the option of going to court and seeking compensation for pain and suffering. Thus the provider is generally protected against the threat of a surprisingly large, or even punitive settlement. And, the patient is paid during the period when he really needs the money.

Incidentally, if the patient feels that truly malicious negligence is involved, he retains the option of suing for intentional injury. Wrongful death also falls into this category.

In the event the provider fails to offer a settlement within this 6-month period, the patient retains the right to use the court system and go for a bigger settlement.

We are betting that insurance companies are not really gamblers and will generally opt for a reasonable quick settlement rather than a potentially unreasonably large slow one.

This generally is how our plan works. There are a number of technical questions that our bill speaks to and that I would be happy to address. Obviously, for instance, the patient and provider won't always agree on what actual economic damage is. In such cases, the courts will still have to decide. Providers retain the right to recover the expenses incurred in defending themselves against bad faith claims. We are making it easier to use the system, but we don't want to encourage even more actions than there are now.

I have become increasingly convinced that there are no quick or comprehensive solutions to our problems. We must do what we often do here in the Congress, and that is attack incrementally. Malpractice insurance costs are an important part of the problem. Our bill, I believe, is a sane solution. Action will send another needed signal that we are serious about getting health care costs under control.

I would like to conclude by saying that this year long review of this subject has convinced me that this is like most other fields, terribly complicated and difficult to deal with.

We have had other versions of this bill and rejected them in favor of what you see before you. I don't advertise it as the perfect magic answer to the problem. It has obviously problems of its own but I do believe that on the whole comparing the present system with this kind of a system I believe that the Moore-Gephardt bill would be a better approach both from the viewpoint of the patient, the injured party, the party with a malpractice claim or a party with a bad outcome which is often what malpractice claims are. Also from the viewpoint of the entire society, I believe this is a preferable system to the system that has grown up over the years and is now, I think, not doing the job that it was originally intended to do.

Let me stop at that point and again thank you for allowing me to be here and make this statement today, and I would be happy to try to answer any questions.

[The prepared statement follows:]

STATEMENT OF HON. RICHARD A. GEPHARDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Thank you for the opportunity to appear before the Ways and Means Health Subcommittee today to discuss the problem of medical malpractice costs. They're intolerable now and getting worse. They have a negative impact on our health care system that goes beyond the financial cost. That's the bad news and there's plenty of it.

But there's also a bit of good news. It is embodied in the legislation we are talking about today. Congressman Moore and I believe that we have come up with a solution. It won't end medical malpractice, but it will make the recovery system cheaper and more rational. That should benefit all patients and providers, including the great majority who have no direct contact with the malpractice problem at all.

Americans are now spending more than 320 billion dollars a year on health care. That's a medical bill of nearly a billion dollars a day and it adds up to more than 10 percent of our gross national product.

Malpractice is a significant part of our national medical bill. Each year more suits are filed. And each year we hear of new gigantic settlements that break previous records. How much the patient benefits from this trend is questionable, though, since only one dollar of every three awarded ever finds its way to the patient at all. Some suggest that malpractice is a transfer program that shifts money from doctors to lawyers when they hear about how much money is diverted into the legal process.

Last year American doctors paid about $1.7 billion for malpractice insurance. That's 17 percent more than they paid the year before. Every time you visit your doctor the bill is inflated by more than $3 to pay his malpractice bill. Hospitals have the same problem. Their room rates are increased by about $5 a day to cover malpractice protection. There's no evidence that things are going to get better.

They may be getting worse. Doctors feel the need for more protection as the size of awards grows. More than 60 percent of physicians now have insurance that will pay a million dollars or more for a single claim.

This results in staggering premiums. Some neurosurgeons now pay more than $40,000 a year for coverage. Some obstetricians pay more than $50,000.

These are extreme. But two years ago the average physician malpractice insurance premium was $5800. In the past decade, such premiums have more than doubled.

Some doctors simply cannot afford them and have chosen to limit their practices instead. A survey of obstetricians found that 20 percent had cut back on high-risk care and that 9 percent had simply stopped delivering babies entirely. That's not a healthy sign.

We now spend a total of $35 billion on malpractice when all the costs are considered. A good part of that comes from defensive medicine that is practiced solely to provide legal protection. This practice is so expensive that it threatens to undermine all our cost containment efforts.

During the last decade, malpractice premiums increased by 131 percent. At that rate, we'll never get medical costs under control. We simply cannot afford to allow that trend to continue.

That is the problem as I see it. Now I'd like to turn to our proposed solution. When Henson Moore and I first reviewed the situation, we were offended by several features of the status quo. There was no rational relationship between the problem and the settlement. One patient would win a million dollars. Another patient, who had the same problem, but a different lawyer or a less sympathetic jury would come away with nothing. When the patient did prevail, he didn't get much of the money.

Meanwhile, doctors and hospitals were changing their style of medicine. The new defensive mode was costing a lot of money, but yielding no improvement in health care. From the patient's perspective, this money was simply wasted.

Our courts were swamped. Providers and insurance companies realized that they could often prevail by simply playing a waiting game. Prompt settlements became unusual. Patients in pain began by having a complaint against our health care system and ended by hating the legal system instead. All in all, we didn't see a very pretty picture.

We wanted to come up with a plan that offered people with real problems settlements that were both fast and fair. Our act begins by encouraging the states to make reforms in this direction for all patients. If they fail to act, the Alternative Medical Liability Act will be imposed on a state to apply to all patients whose care is paid for by the federal government.

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The provider involved—physician, hospital or both—would then have six months to settle the claim for economic loss. If such a settlement was offered, the patient would lose the option of going to court and seeing compensation for pain and suffering. Thus the provider is generally protected against the threat of a surprisingly large, or even punitive settlement. And, the patient is paid during the period when he really needs the money.

Incidentally, if the patient feels that truly malicious negligence is involved, he retains the option of suing for intentional injury. Wrongful death also falls into this category.

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This generally is how our plan works. There are a number of technical questions that our bill speaks to and that I'd be happy to address. Obviously, for instance, the patient and provider won't always agree on what actual economic damage is. In such cases, the courts will still have to decide. Providers retain the right to recover the expenses incurred in defending themselves against bad faith claims. We are making it easier to use the system, but we don't want to encourage even more actions than there are now.

I think all of us agree that health care finance is a very complex area. I've become increasingly convinced that there are no quick or comprehensive solutions to our problems. We must do what we often do here—attack incrementally. Malpractice insurance costs are an important part of the problem. Our bill, I believe, is a sane solution. Action will send another needed signal that we are serious about getting health care costs under control.

Chairman JACOBS. Mr. Moore.

Mr. MOORE. Thank you, Mr. Chairman.

The bill, whatever condition it is in, it is there because of my colleague, the gentleman from Missouri, who has had a long and distinguished history of working in this area. His sole interest is not trying to pick out attorneys as being a problem in our society, and not in any way undo something that is not broken.

The total concept as I understand is our being convinced that in trying to bring down or stabilize the spiraling cost of health care you cannot ignore as the gentleman so adequately testified, you cannot ignore this problem of defensive medicine and high malpractice awards and the premiums for the policies to cover hospitals and doctors from that potential damage suit.

So I want to thank the gentleman for bringing to bear his tremendous knowledge and energy and working on this matter. I am certain if it gets anywhere it will be in large part due to his expertise and efforts and I thank you for being here.

Chairman JACOBS. In case of a dispute, does the provider's opinion about the money value of the economic loss, the amount of the economic loss I should say, does that control? If I make an offer to you of 15 cents, does that automatically implement the structure of this provision?

Mr. GEPHARDT. If you make an offer that is unreasonable and not in touch with economic reality the party who would receive the offer can complain in court about the adequacy of the offer and the courts will decide what is adequate economic loss.

Chairman JACOBS. What I am really getting at is, let's say you wake up one morning and find a sponge somewhere inside you rather than outside, and you go to who you think may negligently

have left that sponge there and the individual says, yes, that is 100 dollars' worth of economic damage to you.

Are you saying—that individual has set in motion the machinery of this proposed law and has discharged his or her duty to make an offer thus precluding you from following the normal procedures in court for your claim?

Mr. GEPHARDT. If this all takes place within 6 months of the alleged occurrence and if they actually tender an offer of economic loss with dollar amounts on it for the different aspects of your economic loss, then the bill is triggered. The offer must be accepted.

However, if the injured party believes that the offer is not adequate and is not in touch with reality with regard to their actual economic loss, they could then go to court and complain that the offer they have been tendered is inadequate and if the court agrees, then the offer must be revised to make it adequate.

Chairman JACOBS. For economic loss.

Mr. GEPHARDT. Correct.

Chairman JACOBS. But the point is if the offer is not paid within 6 months then the normal law of torts applies, as I understand?

Mr. GEPHARDT. That is correct.

Chairman JACOBS. I am invisioning a situation where the provider might make what I call a sham offer. Which court sitting in what way determines it was not a serious offer or, that it was only a sham offer. Would that be before the initial proceedings in the court?

Mr. GEPHARDT. Yes.

Chairman JACOBS. A, was it a serious offer that triggers this mechanism; yes it was, OK, now we decide what the economic loss really is.

Or, B, no, this provider was only trying by stealth to implement the machinery of the legislation but did not say what we say in labor law, bargain sincerely.

Mr. GEPHARDT. I am not sure I follow your question.

Chairman JACOBS. It seems to me a provider under the proposed law might make an inexpensive offer which a reasonable person would conclude was not really an offer at all. I am only asking at what point does this claimant go to court and say, within 6 months no offer was really made, only the shadow of an offer was made and therefore I am applying for damages under the normal common law and the tort rules of the State.

Mr. GEPHARDT. I believe without perhaps fully knowing, if an offer is made, and obviously the law sets out that it would have to be in writing and it would have to be a serious offer with intent to back it up, that triggers the bill and even if the offer is a sham then the person, the injured party, has to go to court and has to have the offer turned over and revised.

Chairman JACOBS. It might be a problem there. It sounds to me just a little like using a penny for a fuse at the circuit box. But it is something I would suggest that you give some consideration to. You have not as I understand distinguished between what is called in my State ordinary negligence or gross negligence, it is negligence as a category or intent.

Mr. GEPHARDT. We do allow you to go to court for intentional tort where there is malice, as I stated in my testimony. But we do not distinguish between normal and gross negligence.

Chairman JACOBS. As usual you have enriched the record with your eloquence. Thank you.

Mr. GEPHARDT. Thank you very much.

Chairman JACOBS. Our next witness is the Honorable John Porter, Representative in Congress from Illinois, a useful Representative, protector of the public purse, presenter of testimony.

We are honored to have you, John. Proceed in your own manner.

STATEMENT OF HON. JOHN E. PORTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. PORTER. Thank you, Mr. Chairman, for the opportunity to testify this morning.

I might say that I am submitting to the subcommittee written testimony for the record and I will simply make some comments on that.

Let me first commend my colleagues Henson Moore and Dick Gephardt for proposing this legislation and also Prof. Jeffrey O'Connell who will testify this morning for his study and expertise that has gone into making the product before us.

Mr. Chairman, I commend you for holding these hearings on H.R. 5400 so promptly.

If we look at our health care system and the costs that have built up for such a long time, those costs being the fastest growing part of the Federal budget, far faster than defense or other social spending, with the medicare trust fund likely to be broke and broke to the tune of maybe $300 or $400 billion by the early 1990's, I think the pressures are very evident that we have to look at the entire health care system to find areas where we can do what we do much more efficiently.

I think that the DRG prospective payment system is one effort in that regard. Medical malpractice reform is one also where great cost savings could be realized through greater efficiencies and money could be far better spent on providing for quality care that is now spent in our very cumbersome system.

The subcommittee has to look to see what different options there are before they get to the final point of saying which is the best approach.

One of those options is to do nothing. However, it seems to me that, in addition to the costs of health care being a growing part of our Federal budget and the part of our GNP increasing as they are in terms of percentage, we also have the problem of our inability to keep up with the very fast advances in medical technology and the demand for those advances. If we have the ability, for example, to implant an artificial heart, the demand for that increases. We are going to have very, very difficult problems having the resources to meet those demands and probably a very difficult problem to avoid rationing the kind of health care that we have.

So I think the status quo in this area is very unlikely. We are going to have to do something to solve this problem because of the great pressures upon our society and upon our medical providers.

Second, we could leave to the States the option of acting without any further Federal guidance or direction. That of course was where the problem was first addressed in the mid-1970's. At that time, I served in the Illinois General Assembly on our task force on medical malpractice. We made a few changes in the law. We provided some pretrial screening but little was done to address the problem. Doctors learned at that time they could pass along the costs of higher premiums to their patients and the problem really was simply buried and not addressed in a meaningful way.

Also it has to be said, that most State legislatures, if they are not at least 50 percent attorneys, attorneys certainly have great influence on State legislatures. Accordingly, it is unlikley that we will see States take meaningful action in that area any time soon.

Third, we could have a Federal Government simply address the problem. Certainly the commerce clause gives us sufficient jurisdiction. We could adopt what might be known as the National Control of Medical Malpractice Costs Act, preempt State law and have national uniformity and all that goes with it.

However, I think that would violate very greatly the traditions of sharing the jurisdiction between the Federal and State governments. It would be an unlikely choice for the Congress to make.

So it seems to me the only real approach, the only approach that can address the problem in a meaningful way is for the Federal Government to pass legislation that gives States incentives to act.

Of course, we have done that just last night by passing the national drinking age legislation that does not take Federal jurisdiction but rather says to the States we are going to give you great encouragement, not only the carrot we gave before, but the stick, to do something about a very serious national problem.

So there is a great deal of precedent for addressing the problem in that way. The question then becomes: What kind of model do we use in Federal legislation to best address the problem?

One choice would be a worker's compensation model. We could set up a system in each State that is modeled on worker's compensation legislation, noneconomic losses could be squeezed out in large part through that system. However, that kind of a change is far too massive for the Federal Government to encourage and one that would not be my first choice.

Second, we could try to establish some kind of national arbitration system or State arbitration system under Federal law. Once again it is very clear that if we attempted that direction the matters end up in court anyway because the Supreme Court has said you simply cannot deny access to the courts.

Third, we could adopt a nofault model of the type that H.R. 5400 proposes. This is the approach that I think makes the best sense and addresses the problem. I certainly commend the gentlemen who have introduced this legislation. They have described it I think properly as a point of departure and the beginning of addressing a problem in a meaningful way.

The legislation has several advantages. First, it doesn't point an accusing finger of negligence at the doctor or cause a sensational publicity if there is an act of malpractice. It gives a chance to solve that problem quickly and easily, and resolve it in an efficient way

without all of the attendant negligence factors that seem to go with our tort system.

You mentioned earlier in asking my colleague from Missouri a question about the frivolous offer made. But it seems to me, and Professor O'Connell can correct both of us, that it doesn't matter whether the offer is a frivolous one or not. Once an offer is made the medical provider that is allegedly negligent has given up any chance to litigate the negligence issue. In other words, they have positively given away that right and the only question remaining at that point is how much? What are the damages in that case?

That can be resolved, if it cannot otherwise be agreed, by the court. Anyone making an offer according to the law is giving away their right to access to the courts to litigate the negligence question. So whether it is a frivolous offer or not intended, they have given up a great deal.

Chairman JACOBS. If I may interrupt at that point. I can understand that there is a concession of negligence.

On the other hand, there is also the gain of exemption from any question of pain and suffering. Would that be fair?

Mr. PORTER. That is right. But the only question remaining is, how much is the economic loss attendant on this particular injury?

Finally, let me just wind up by saying what we are looking for is not only a more rapid resolution of the system and squeezing out of economic loss, but greater uniformity, even-handed justice, security and protection for the individual who has been injured.

I think the approach of this legislation accomplishes that, and certainly the institution of a system of this type would tend to lessen the need for the practice of defensive medicine. That is where a great deal of the doctor's time, a great deal of the hospital's time, and a great deal of the resources of our medical providers are wasted, in procedures that are only necessary to protect against lawsuits that might otherwise occur.

That is what we have to be certain about, that we squeeze out and allow the practice of medicine to be one that is directed toward the problems of people and not simply to protect the doctor from liability.

So I think we are going to see great pressures for action, Mr. Chairman, and I think H.R. 5400 is a very fine approach. I think it should earn a great deal of discussion and testimony.

I would hope that the subcommittee could find a way of quantifying the loss to society through the practice of defensive medicine and through the system that we have now of recompensing injuries. Maybe then we could send to the floor of the House, and hopefully pass, legislation that would encourage changes in our system that would address this problem and make our entire health care system more efficient while still preserving, for the individual who is injured, the right to a recovery for his or her loss.

I thank the Chairman and the subcommittee for this opportunity to testify today.

[The prepared statement follows:]

STATEMENT OF HON. JOHN E. PORTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

I appreciate the opportunity to appear before this subcommittee today to discuss H.R. 5400 and the subject of medical malpractice litigation and its affect on health care costs. I want to take this opportunity to commend my friends Henson Moore and Dick Gephardt for working together in a bipartisan fashion to introduce this very important bill.

First, I'd like to speak generally on the subject of health care costs and medical malpractice. Health care costs, as this subcommittee well knows, are the fastest growing part of the Federal budget. Another important consideration, of course, is that the Medicare trust fund may be going broke. It may occur sometime in the early 1990s with deficits projected as high as $300 or $400 billion. It will require, to cover it from a revenue standpoint, about a 50 percent increase in Medicare taxes, and I must say that I don't see any great rush in the Congress to look to revenue to solve the problem.

We can assume one of the best places to cut costs is to address the problem of medical malpractice. H.R. 5400 sets out to investigate that possibility. Now, hospital administrators and doctors shouldn't jump out of their chairs, H.R. 5400 wouldn't take us back to the doctrine of charitable immunity. Doctors are going to continue to be subject to being sued. I think they ought to be. It helps very much in terms of their own responses and their own responsibility in providing health care to the American people. Besides, I think we've reached the point in our society that every injury, even in the absence of negligence, is likely to be compensated in some way; whether it's product liability or physician liability, in a sense, both have become strict liability.

Now, there are a number of potential approaches or options to addressing the medical malpractice problem.

One thing that is possible is that we do nothing, that the status quo be retained. The trial lawyers would certainly like that, but frankly, I think I see too much pressure for cost savings and efficiency to give trial lawyers the status quo. Consider that there is not only a crisis in health care costs, but our medical capabilities continue to improve—capabilities to discover new cures, new procedures, new devices; to implant artificial hearts; to transplant livers and pancreases and lungs—all which increase the demand for all such life-prolonging operations, a demand that will increase costs even further. And we'll be, in my judgment, extremely lucky if we can avoid rationing the application of these new discoveries, and avoid deciding who will get a new heart and who will not. So here, as in other areas of health care, the status quo looks very unlikely at least for very long.

Our second alternative in addressing the burden of medical malpractice costs is that the states could act. But if you look back in the mid 1970s—and I served at that time in the Illinois General Assembly on our Medical Malpractice Task Force—really very little was accomplished. In Illinois, we put in some pre-trial screening and some changes in the rules of evidence, but those were very, very small, and very little progress was made. And I think that was true in most states.

There's also the fact in the state legislatures that the trial lawyers, if they don't make up half of the general assemblies or state legislatures in this country, half of the membership, they have one of the best lobbies in the state capital. It's very unlikely we can get any great action out of the states with that kind of pressure. And even so, there would remain the problem of even-handed justice, and I think this is the time to address that problem as well.

It is fair to have a $4 million recovery in one courtroom, and then, having the same facts, in the courtroom next door a $400,000 recovery. I'm afraid its justice not even, but very uneven. It seems to me that if we were going to address the malpractice question, this is a very good place to address the fairness issue as well. And I don't think that fairness will be established through any state by state solution.

Another option concerns product liability, which is now being addressed in the Senate, where Federal standards would be imposed under legislation proposed there. This gives hint, I think, of the possible direction that we might go in addressing this problem.

There's a fourth alternative, and that is that the Federal Government could act alone, with respect to the whole problem of medical malpractice. It could act completely, and pre-empt the field. The Supreme Court in the 1940s, in the case I believe Mr. Justice Douglas decided, defined the commerce clause of the Constitution to cover the farmer feeding the corn he grew on his own land to the cattle he raised on his own land as an act of interstate commerce. Ever since, we've assumed that

anything is in interstate commerce, and therefore subject to Washington's regulation.

Presumably then, we could have a National Control of Medical Malpractice Costs Act, pre-empt state law, have national uniformity and all that goes with it. First, I think this approach would be totally out of our national tradition. If we don't have precedent any longer, we at least do have traditions.

We see, however, that some of this approach is likely to occur, for example, in the area of legislative solutions to the problem of asbestos injuries. We're seeking that right now in Congress. Manville Corp. has had 28,000 individual cases filed against it all across the country in many, many jurisdictions. In a case like this, we're going to see the Federal Government pre-empt the states, and provide for a legislative solution, to meet the needs of those who are injured. Those needs obviously couldn't be met out of the resources of the corporation or its insurance carrier, if indeed it has an insurance carrier. Injuries from hazardous wastes is another subject we may see addressed legislatively and directly by the Congress. However, I don't think we're going to see Congress act alone in a generic way in reference to medical malpractice.

So it seems to me that the only likely approach is for Congress to pass legislation to give incentives for the states to act. We're seeing this approach in many areas—the 55-mile-an-hour speed limit is one example of it. Now we're moving toward having a minimum national drinking age to address the problem of drunk driving in the same way, with financial incentives to the states to adopt 21 as the minimum drinking age in each state across the country.

This approach pervades our Federal-state relationship. In medical malpractice we could use incentive grants, that would be the carrot; and a cutoff of Medicare or Medicaid funds in some percentage, that would be the stick. But whatever type of approach is used, this looks to be a very likely way to address the problem.

What would be the approach, then, in terms of Federal legislation? The first one might be based on a workers' compensation model. Here the principle is that if an injury is sustained, an individual is entitled to compensation, regardless of negligence. There would be no accusing finger pointed at a hospital or a doctor if that type of approach was used. Uniformity of awards could be more certainly insured, again under Federal standards. Non-economic losses presumably could be largely squeezed out in such circumstances. At the same time, all of the oxes would not be completely gored since lawyers would still be needed, although the form would be different and overall compensation probably less. Nevertheless, I think there is a lot of appeal in this kind of approach.

Second, we could try some kind of arbitration system established by Federal law. But it's hard to see how this would work much better than a workers' compensation approach. More oxes would be gored, and matters would still end up in court, because courts have uniformly ruled that binding arbitration is not permissible, it's unconstitutional, access to the courts must be guaranteed.

Third, we could go on a no-fault model that could be imposed on the states under Federal guidelines. This "no fault" approach is the proposal before us in H.R. 5400. The bill is before us at the best possible time in that it serves as a point of discussion for Congress, the medical community and the American people to debate this very important subject.

The legislation that Reps. Moore and Gephardt have proposed is very modest in scope. Its coverage is limited to Federal health programs such as Medicare and CHAMPUS. And this is not, as we undoubtedly well know, the area where most medical malpractice claims come. The elderly don't tend to sue their doctors or their hospitals. Those big recoveries come in cases of far younger people where the potential loss, the economic loss, is far greater. So the bill is modest and limited in its approach.

Under the bill, the patient would notify the health care provider that an injury had occurred. The provider would then have 60 days in which to make a settlement offer. If no offer was made, the patient could then go to court and presumably recover what they can recover in court today. But if the offer is made, it will cover only the economic loss, not the loss, for pain and suffering or attorneys' fees or court costs or anything else. The patient is then foreclosed from going to the court, except regarding the reasonableness of the amount. In other words, the question of negligence or liability has been resolved by the making of the offer. That's the "no-fault" part.

There are a number of exceptions provided for in the bill that do allow a patient in certain circumstances to go to court. But the no-fault concept is one that would be appealing in a number of different ways. There's no accusing finger pointed at negligence of the doctor or the hospital, no sensational publicity and there is a faster resolution to the problem. Many people wait four, or like in my state, five

years or more to go to trial and make a recovery. Witnesses die and move away. The difficulty of proving the claim becomes greater and greater. This no fault approach would lead to faster resolution. No large attorneys' fees would be involved. There is an estimate nationally that 42 percent of the amounts recovered from medical malpractice claims are in fact turned over directly to the attorneys or to provide for costs of suit. The insurance companies get 30 percent for their overhead, and only 28 cents out of every dollar goes to the victim.

What should the Congress look for in any approach to solving the problem? Greater uniformity, and therefore greater, more even-handed justice; security, greater protection for the injured person; a lowering of costs through lower premiums, by reducing non-economic losses being compensated, including attorneys' fees and court costs; and a faster resolution of conflicts. But I think the most important factor that the Congress should look to in addressing this problem is to squeeze out of our health care system the costs of practicing defensive medicine, both the direct cost and the indirect costs. The indirect costs in terms of the loss of physician and hospital time and resources, all estimated at 30 percent of our total health care costs are over $100 billion a year, a sum of money well worth saving.

In conclusion, it seems to me that in this entire area as others in the health care field, the pressures to do something are great and will grow. The most likely approach will be that Congress will mandate a program for the states to adopt with local variations, but under Federal standards. This is the approach I would favor. I think it's too early to tell whether H.R. 5400 is the solution we should choose. It is certainly a good start. This hearing today will help to shed light on the various options. I look forward to carefully reviewing the statements of the others who have spoken on this very important subject and to participate actively in its solution. I thank the subcommittee for inviting me to testify.

Chairman JACOBS. Mr. Moore.

Mr. MOORE. Thank you, Mr. Chairman.

I want to thank the gentleman for being here. He has shown a consistent interest in this matter. And, indeed, quite recently I attended a seminar which he hosted here in Washington with a number of knowledgeable people discussing this issue of medical malpractice and what to do about it. We certainly welcome his interest and his testimony. It is very consistent with the position he has taken for a long time.

We can certainly use your expertise.

Mr. PORTER. Let me say, Henson, that I catch it on the other end serving on the Health and Human Services Subcommittee of Appropriations, where we have to provide the funds to pay for medicare and medicaid and all the rest. So that is my interest in the entire issue.

Mr. MOORE. We have the same interest, all of us. Thank you.

Mr. PORTER. Thank you.

Chairman JACOBS. Our next witness is Prof. Jeffrey O'Connell, professor of law, University of Virginia.

STATEMENT OF JEFFREY O'CONNELL, PROFESSOR OF LAW, UNIVERSITY OF VIRGINIA SCHOOL OF LAW

Mr. O'CONNELL. Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Moore.

Mr. MOORE. Mr. Chairman, thank you.

Before Professor O'Connell testifies, I just think those in attendance, as well as the staff and press also, know that this gentleman is the source and inspiration for this legislation. This is something he has been working on for a great number of years, something he perfected and brought to the attention of Congressman Gephardt and myself over a year ago as a suggestion in the overall picture of beginning to stabilize health care costs.

He is the expert as far as there being any potential expert on what this legislation is trying to do, where it came from, what its theory is and how it works. He is the man who researched it, the man who wrote it, the man who understands it. And, as far as I am concerned, he is one of the most brilliant legal minds in the country today.

We have been very privileged to have been able to work with him and take his idea and working with him to turn it into meaningful legislation. So I am very privileged to have worked with him and to know him, and his testimony should be given the utmost attention in terms of legislative history. It is from his mind that this legislation comes.

Chairman JACOBS. Professor O'Connell, we welcome you, particularly with that glowing description. The Chair can only say he has always been frightened of law school professors, and he is all the more so after what Mr. Moore said.

Please proceed in your own way.

Mr. O'CONNELL. Thank you.

Let me say that whether or not, after this bill is pulled apart, with the tugging and hauling that goes on, the origin and inspiration of it will be sought after, remains to be seen. But, I have benefited tremendously from Congressmen Gephardt and Moore and their staffs. The bill is, by no means, the rather crude draft I started with. It is a much better bill. I am tremendously impressed with the policy insights and drafting skill of the public servants I have worked with in honing this.

Let me talk a little about it. It is designed to add to what I think is undeniably the present lottery system of present malpractice litigation. As Congressman Gephardt said, some people are richly rewarded; only, it is true, if they are tragically injured. But others in the same situation get little or nothing. In a way, the trial lawyers, plaintiffs' lawyers, are hoisted by their own petard in trying to assert, if they were to do so, that the present system works smoothly.

Let me say I share Congressman Moore's belief that there is no point in accusing trial lawyers of inadequate conduct—of conduct against the public interest. They believe the present system serves the public interest. There is little to gain by hurling accusations against either the insurance industry or the trial bar. Given the present system, each of them behaves the way you and I would behave were we in their position.

But I think it is undeniable that the present system is an extremely tangled and difficult one, as the trial lawyers will have to admit. After all, they charge, and I think earn on the whole, 30, 40, 50 percent of payment to claimants in order to help get it. But, obviously, unless it were very difficult, they couldn't justify charging 30, 40, 50 percent to help get it.

Nor is it fair to assert that the basic problem of the tangled nature of the present system is the intransience of insurance companies as some lawyers are prone to do. Trial lawyers believe in and vigorously support a fault-finding system, an accusatory system. If you are going to accuse health care providers of fault, of course it shouldn't surprise us that they defend themselves, that they would put you to the proof of their fault. Oftentimes, they will

be convinced they were not at fault and will therefore defend themselves.

So the "shin-kicking" litigation that results is not the fault of intransient defendants or greedy plaintiffs. It is a fault of a very tangled and difficult event that needn't be so.

So we got huge transaction costs. I did calculations a few years ago that estimated that only 27 cents out of the malpractice dollar ever gets to the hands of the claimant, after all the insurance overhead and legal fees are deducted. And long delays, not only months but years, ensue before any substantial payment gets to a seriously injured person.

Note, if you will, an anomaly here, looked at from the insurance point of view. This is the worst insurance mechanism we have—far more spent on overhead, far fewer percentage of people being paid, longer delays than under any other mechanism of insurance, whether health insurance, life insurance, disability insurance, et cetera. And yet, this is the insurance mechanism that is constantly expanding.

Every year, we spend more and more on tort liability while we cut back on better forms of insurance. We cut medicare, private employers cut back on health insurance to their employees. With more and more unemployment, less group health is available. Disability benefits are cut privately and publicly.

Look at the tremendous problems we have under social security. So we are contracting and subcontracting from all these other reasonably good insurance mechanisms and expanding this one, an anomaly indeed.

I suggest to you that the solution—not a perfect solution, certainly not—but a solution is here and indeed it was a solution thought up 100 years ago by Bismarck, of all people—not the greatest social visionary of his time. But Bismarck came up with the solution here in the first great wave of accidents, which were, of course, workplace accidents. He saw with a clarity that should shame us 100 years later, that it was foolish after every industrial accident for an employee to have to claim against his employer based on the fact that the employer was at fault and he, the employee, was free from fault. This was seen as a very cumbersome, a very dilatory and inefficient and, in essence, a very cruel system.

He substituted an elimination of the two variables that overwhelmingly cause most of the problems. Those two are: Trying to determine who is at fault; and trying to determine the monetary value of nonmonetary loss. If you have those two variables in any insurance mechanism, and they only exist under tort liability, you are going to have a mess.

Bismarck saw this and enacted workers' compensation to solve it. Then the British Empire, as it was then, enacted the same solution. And then between 1910 and 1920, in North America, both in Canada and the United States, we enacted it.

The curious thing, I suggest to you, is that that solution has not been extended much. It has not been a perfect one, but who comes before this body, who goes before any State legislature, seriously advocating that we abrogate workers' compensation and go back to the tort liability system for employer-employee injuries? No one does that—they would be greeted with hoots of derision, if they did.

Yet, why is it that we maintain the same system that Bismarck saw as abysmal when the health care provider is the cause of injury to his patient? We have this same ludicrous, cumbersome litigation over who was at fault and what is the value of nonmonetary loss.

Now, Congressman Porter rightly says that to inject a massive workers' compensation bill into the medical malpractice area would itself be cumbersome. Why? Because it would be so difficult to define the insured event. We have learned that you can provide that if an employee is injured in the course of employment he will be paid automatically for his wage loss and medical expense—not for pain and suffering. But he will be paid automatically, even if he was at fault and the employer was not at fault.

It is much tougher to define that insured event for medical malpractice. We cannot legitimately say to any health care provider, whether a hospital or doctor or nurse, that anybody injured in the course of health care treatment will be entitled automatically to be paid by you for all their further medical expense and wage loss. Why? Because it is so hard to know when I, as a patient, go to you, as a doctor, and I get worse, whether my worsened condition is the result of your treatment of me or whether it is due to the presenting complaint that sent me to you in the first place; whether it was not perhaps an inevitable result of the malady that sent me to you.

Trying to separate out what is the sequela of the medical treatment and what is the sequela of the patient's condition makes the so-called no-fault solution for medical malpractice extremely difficult. Note that this bill tries to elude, if you will, that problem of defining the insured event in advance. We admit, in drafting this bill, we cannot sit down and put down a schedule of everything that should be paid for in advance, no matter how bright the staff of this Congress is nor how able the Congressmen themselves are. I don't think we can do that.

But what we can do is say to a health care provider, after the event, as you are monitoring the condition of your patient and you see something has gone wrong that might result in a malpractice claim, we will give you incentives not to litigate; not to hide the result but come forward, acknowledge the adverse result, whether or not it might ultimately result in a successful malpractice claim, and tender to that patient his real loss, to end the adversarial system.

You raise a good point, Mr. Chairman: How do we know what is a good offer? But the bill defines that. The bill says, unless an offer is made to underwrite all of the claimant's further medical expenses due to the adverse result and his wage loss, then the offer does not foreclose a tort claim. So there is no possibility of a frivolous offer here. The offer must be under the terms of this act for full medical recompense, including rehabilitation, and wage loss. If the offer does not entail those very full benefits, it does not foreclose a tort claim.

One might ask: What is to prevent this from happening today? Why don't health care providers, who are on the whole interested in their patients, who have won the trust of their patients or else the patients would not have come to them—why don't health care providers, after an adverse result, tender patients' economic loss?

The answer is, if you know much about the mechanics of litigation, that today if the provider promptly after an operation comes forward within days or a few months and offers the patient all his economic loss, the plaintiff's lawyer understandably, given the present rules, assumes that if they offer this much this early, there must be a lot more there; "they would not come forward with this offer unless we can get much more." So the health care provider doesn't make this tender, which smacks of an admission and which encourages higher expectations on the part of the claimant and his lawyer. And if he does, the claimant's lawyer treats it as a signal not for settlement but for a much more aggressive demand.

What this bill does is say to the provider, find the adverse result, do not hide it, come forward with a reasonable offer of the actual losses that your patient will suffer. Those losses will be payable periodically as loss accrues, as in the case under disability and health insurance and workers' compensation, and most other forms of insurance—not in one lump sum the insane system, our tort system, demands—and no other insurance system does. If you come forward with this reasonable offer, you will be guaranteed it will not be a signal for further bitter litigation. It must be accepted. It will end the matter.

I might say that I have tried to anticipate some other questions that might be asked about this bill. The question is asked: Won't there be adverse selection here? Won't insurers and health care providers simply make an offer when they are clearly liable in tort and not make an offer in any other cases so all we will do is let the people with valid tort claims get paid less, and everybody else will be left in the maw of tort law or with nothing forthcoming?

Keep in mind, the provider will be at a tremendous incentive to come forward with a tender, not only in clear cases of liability but in marginal cases as well. The health care provider will say to himself, "If I am going to spend more on a defense lawyer than the claimant's net economic loss, after all his health insurance is paid, and his sick leave and disability is paid, if I will pay my lawyer more than my patient has lost, I am under an incentive to get rid of the claim. Also, am I going to pay more to duplicate all my patients own health insurance, as I am required under tort law, either to the patient or in subrogation? If so, I will make this tender. If I am looking at a large pain and suffering award, even though I think I will win, if the possibility of a large pain and suffering award is greater than the net economic loss"—if any one of those three variables or a combination of them means that the health care provider will not only save money, but the agony and bitterness of litigation by making the tender of net economic loss, he will be prompted to do so.

The question has been asked: What do you do with a person grievously injured with relatively small net economic loss, a person who has all his health care covered by Blue Cross/Blue Shield, who is on a pension such that he is not going to lose wages, who is a homemaker who doesn't have a job where one will lose wages, and yet has suffered some terrible injury—loss of a leg, blindness in one eye, some terrible injury? In other words, the economic loss is marginal. Do you provide that tendering economic loss forecloses a claim in that case?

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Well, at first blush that seems harsh; and on second blush it seems harsh. But what we are saying here is this: We are facing an economy where insurance dollars are very precious, and if a person has not suffered dollar losses, we are not going to pay him or her dollars. That seems to me, in a time of tremendous hardship for many people, not to be as harsh as it might seem at first and second blush. That is, using insurance dollars for dollar losses is not an irrational decision.

We made it with workers' compensation. Under workers' compensation persons who suffer grievous psychic injury and relatively little economic loss are largely left in that position. As an insurance proposition that has worked, and we have lived with it.

On the other hand, you could draft this bill to say that in very egregious cases we will allow tort actions. You could say, for example, in an alternate provision which we could consider, that if the economic loss which is payable by a tender is so derisory in comparison to all the loss the claimant suffers, such that if such a settlement were effected voluntarily a court would overturn it as manifestly inadequate, then we would allow the tort action. There is a danger that that exception would be exploited and made larger than we would anticipate. But at least we already have legal criteria in making it very difficult to overturn voluntary settlements; we could in effect say society under this bill has approved such involuntary settlements, and we will not overturn them unless a voluntary settlement for a similar amount would be overturned.

There are many other provisions we could talk about. This bill is not written in stone. I myself have suggested—and will suggest—some alternative provisions.

Let me say this, though: The medical malpractice reforms that were enacted in the 1970's were all one-sided reforms. They were reforms that took away from the patient rights that he had with no quid pro quo; a cap was put on pain and suffering; he was forced to arbitrate; collateral sources were deducted from his recovery. Again and again, if you go through the list, not one was designed to make things easier for the claimant. And, even so, those reforms have failed.

Why? They have failed because they did not learn the lesson that Bismarck taught us. If you leave in the insured event, the issues of who is at fault and what is the value of pain and suffering, you will have a nightmare of an insurance mechanism.

There is another lesson that we can now learn that was not true in Bismarck's time. When we are dealing with precious insurance dollars—and, God knows, anybody looking at medicare costs has to concede such dollars are precious—if we have an insurance mechanism that pays people all over again when they have been paid from other sources of insurance, that is profligacy we cannot afford.

Those three crucial variables are covered in this bill. And any bill, I suggest, which does not address each of those three features, which does not eliminate litigation over fault, which does not eliminate payment for pain and suffering, and which does not eliminate duplication of collateral sources, is doomed such that we will be back here in a few years fighting this whole battle again.

I really am very flattered that an academic idea would get this kind of attention. I am flattered that very pragmatic people would devote their attention to it.

I thank you for your attention to it, and the opportunity to appear.

[The prepared statement follows:]

STATEMENT OF JEFFREY O'CONNELL, PROFESSOR OF LAW, UNIVERSITY OF VIRGINIA LAW SCHOOL

My name is Jeffrey O'Connell. I am John Allan Love Professor of Law at the University of Virginia Law School. My address is School of Law, University of Virginia, Charlottesville, Virginia, and my telephone number is (804) 924-7809. I am the co-author of the principal work that proposed no-fault automobile insurance and have written recently about ways in which to apply modifications of those ideas to malpractice occurring in the course of health care.[1]

My statement in summary is that H.R. 5400 makes necessary modifications in the tort system for medical malpractice and provides a fairer and more efficient system for compensating patients who suffer malpractice.

Our system for compensating patients for medical malpractice is a disgrace. It is wasteful, cumbersome, expensive, and most importantly, unfair.

The vast preponderance of the resources consumed in the process is expended in the arcane, emotional and often arbitrary allocation of fault through ordeal by trial; only a small percentage goes to compensating the victim. Many victims of malpractice are not compensated at all for their injury; a very few others win far more than their actual losses. Insurance premiums for malpractice coverage are increasing at a rapid rate; it is estimated they will increase 20–30 percent this year, with no relief in sight. Some doctors in large urban areas are paying upwards of $60,000 per annum! In addition, the AMA has recently estimated that $15 billion are consumed each year in physician costs alone in defensive medicine, which is not only expensive but can often adversely affect the quality of care.

The current system serves no one other than the lawyers and expert witnesses who drive and thrive upon it.

Medical malpractice might appear an appropriate area for application of the no-fault concept. However, it is often far from clear whether an adverse result is the result of improper medical care or merely the natural workings of the malady that sent the patient to the health care provider in the first place.

In health care, therefore, the malpractice system based on fault cannot be completely abandoned. But the current system can be modified to encourage payment for more patients who suffer from adverse results without resort to wasteful and prolonged litigation. H.R. 5400 would do so. It proposes reforms to provide fair compensation in a less expensive and more efficient and humane manner.

The proposal sets forth "model" legislation for the states to consider as a means of reforming their medical malpractice system for all patients. If a state does not enact such a reform, the changes made by the bill would go into effect on January 1, 1987, for recipients of Federal health care assistance, including Medicare and Medicaid beneficiaries, Veterans, and Federal employees.

Under the proposal, a health care provider would have the option within 180 days from an adverse outcome which could give rise to a malpractice action to commit to pay to the patient periodically the amount of the victim's economic loss (net of any payment from third sources such as the patient's own health insurance). These losses would consist mainly of compensation for costs incurred in any further medical and hospital care, rehabilitation, nursing care, wage loss, the cost of obtaining a housekeeper, adapting the patient's house and car, etc.

Once such an offer had been made, the patient's ability to pursue a malpractice claim would be terminated (with certain exceptions). In exchange, then for the provider's prompt assumption of an obligation to pay for economic loss, the patient would surrender his claim for non-economic loss. But if the health care provider does not make an offer within the required period, the patient could proceed with a malpractice action as under current law.

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[1] See, O'Connell, "Offers That Can't Be Refused: Foreclosure of Personal Injury Claims by Defendants' Prompt Tender of Claimants' Net Economic Losses," 77 NW Law Review 589 (1982).

The bill would not permit a provider to terminate a malpractice claim where death resulted from the treatment or where the provider's malpractice was intentional.

This proposal does not require any health care defendant to make a tender. Any such requirement would obligate the health care provider to pay losses whenever an untoward result occurred regardless of fault—an across-the-board no-fault approach which is not feasible.

The proposal should reduce the extent to which defensive medicine is practiced and thus improve the quality of care and reduce the costs of health care. Physicians attest that because of the increase in malpractice claims and excessive awards, they order more tests and provide more treatment procedures than they otherwise would. By definition, physicians are taking these steps not because they believe there is a medical justification but because they perceive inappropriate pressure from the malpractice system. To the extent that the proposal would avoid fault-finding (as well as some of the extremely large verdicts—which are the ones which make the headlines and to which the physicians naturally react) it would reduce the pressure on physicians to order tests and treatment procedures for legal protection purposes only.

The proposal would continue reasonable deterrence against malpractice. The possibility of being held liable would remain. It is only by guaranteeing payment of an injured patient's economic loss—a not insignificant commitment of itself—that a malpractice claim could be foreclosed (and not in every case even then). Professional pride, the opinion and review of one's peers, and the fear of adverse publicity are all effective deterrents to malpractice. None of those would be eliminated by the proposal. With workers' compensation and auto no-fault laws, society abandoned substantial blocks of liability based on fault, apparently without any adverse effects on deterrence of negligent conduct.

Most importantly, the proposals would encourage providers to compensate patients promptly for any actual losses suffered by them because of adverse medical results, avoiding the wasteful and bitter lottery of litigation.

Chairman JACOBS. Mr. Moore.

Mr. MOORE. In your opinion, is it constitutional to do what we have done in this bill, and that is to limit recovery to economic loss in lieu of a jury trial for pain and suffering?

Mr. O'CONNELL. I have no doubt it is constitutional. I also have no doubt it will be litigated. Everything is litigated as to whether it is constitutional. That is a great indoor sport in America.

If a reasonable quid pro quo is offered in return—namely, generous payment for actual loss promptly made without litigation—the common law right can be abrogated. In Illinois, which ruled its cap on pain and suffering unconstitutional, the court made the point there was no quid pro quo offered. A cap was put on what the claimant could get, but the bill didn't make it easier to be paid.

I think the quid pro quo is clear enough that the bill passes constitutional muster.

Mr. MOORE. Professor, as you envision how the bill would work, who will decide between the hospital and insurance company, or physician and insurance company, whether or not to make this tender offer, and how will they decide it?

Mr. O'CONNELL. I think the bill is wise in that it doesn't purport to change the present system in that regard. Under present insurance contracts, some health care providers reserve the right to veto any tender; other insurers insist on the right to make a settlement offer regardless of the insured's wishes.

We don't want to dictate to the provider and his insurer who will control. We leave it to them, as it is now, to work that out.

Mr. MOORE. In the system envisioned by the bill, there would be a savings of money on the savings of litigation, punitive damages,

pain and suffering, that sort of thing, that would no longer be the tenders of the offer.

Do we expect that this money will be used to pay more claims of patients who are getting nothing under existing law, or is it a realistic fear that this money will be pocketed as additional profits by insurance companies?

Mr. O'CONNELL. Keep in mind that an insurer and the health care provider will get the benefit of this bill if it guarantees to pay all the net economic loss of patients. That is still a substantial burden.

We are encouraging the dollars to be used for payment of net economic loss rather than litigation expenses, and in duplication of collateral sources and for pain and suffering. It may well be that some insurers will make larger profits under this scheme than they do under the present system. I can't guarantee they won't.

On the whole, though, the insurance industry is not one where there is difficulty of entry. It is a competitive market, especially for medical malpractice, which is highly specialized. You have highly skillful purchasers of insurance in terms of medical societies and hospitals. We can leave it to the providers driving a bargain to get a reasonable malpractice rate from a varied number of sellers.

Mr. MOORE. Competition in the marketplace?

Mr. O'CONNELL. I would think that is a much better guarantee of insurance costs than you and I trying to figure out a regulatory device to control them.

Mr. MOORE. Another practical consideration is the fact that, how do we know the situation won't occur where the hospital, physician, or insurance company will only make a tender in the most serious case where they know they will be sued and they know they are facing a big judgment, perhaps? How do we know that will be the only case rather than taking care of patients who have had injuries and are getting nowhere in the tort system now, but may think they will get somewhere under this bill?

Mr. O'CONNELL. I tried to address that. But, let me readdress it, because I think it is a crucial question, one the critics of the bill—and the bill shouldn't survive unless it can survive that kind of scrutiny—ought to ask.

I emphasize there are all kinds of incentives on the provider to make a tender in the marginal case where he is not sure that he is liable. Any time he looks at his litigation costs and says, "I will likely spend more on a lawyer to defeat this marginal case than the patient's real losses, I will make a tender." And the more marginal the case, the more he will probably have to spend on a lawyer. And note what lawyers cost defending these cases—these are extremely demanding on both plaintiffs' and defendants' lawyers. We are talking about skillful people. And every minute they work, the meter is ticking on both sides.

So, every time the health care provider looks at litigation costs and concludes they will exceed what the injured patient's net economic loss is, he will be under strong incentive to make that tender, as well as being prompted by the other savings he can make by making a tender.

I think there will be many, many tenders in marginal cases. If there were not strong evidence that that were the case, the bill shouldn't pass.

Mr. MOORE. Professor, I want to thank you for all you have done in the past and for being here and testifying. I am sure in the months to come, we will enjoy your expert assistance in this matter.

I read the professor's testimony. I don't know which was better—the oral testimony or the statement. I would ask that we make as part of the record the gentleman's testimony.

Chairman JACOBS. That will be the case for all witnesses today who wish to submit it for the record.

Professor, just for the record, loss of wages or loss of income means future loss as well as current loss.

Mr. O'CONNELL. But payable periodically as under workers' compensation. You would not be paid a lump sum for all wage losses that will occur in the next 20 years; you would be paid month by month.

Chairman JACOBS. That is the way it is getting to be anyway, isn't it?

Mr. O'CONNELL. That is right. That is increasing under structured settlements. But this guarantees that that will be the case.

Chairman JACOBS. I might say, I suppose a lot of people are familiar with Teddy Roosevelt's observation that what is constitutional depends on whether the fifth Justice comes down heads or tails.

But maybe for the record, people would like to know what the former Governor of my State, Roger Brannigan, once said at a banquet to Justice Warren: "I just took an oath to uphold whatever you have in your head."

We thank you for your contribution.

I guess we will adjourn for a few minutes and vote, and be right back.

[Recess.]

Chairman JACOBS. The hearing will continue.

Our panel includes the American College of Obstetricians and Gynecologists, Charles P. Gibbs, member, Professional Liability Committee; Association of American Physicians and Surgeons, Inc., Kent Masterson Brown, general counsel; American Association of Neurological Surgeons, Congress of Neurological Surgeons, Donald H. Stewart, Jr., M.D., past president, Congress of Neurological Surgeons; and American Medical Association, James S. Todd, member, board of trustees.

Because of our witness list, we have to ask that the 5-minute rule be observed. I know each of you has a capacity to be concise and eloquent at the same time, and the way we do it here is that we take 5 minutes per witness, both individually and in the aggregate. So if someone wants to yield a minute or two to someone who is brighter or more interesting, that would be permissible.

I ask the panel to proceed in its own manner.

STATEMENT OF CHARLES P. GIBBS, M.D., MEMBER, PROFESSIONAL LIABILITY COMMITTEE, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Dr. GIBBS. Mr. Chairman, members of the subcommittee, my name is Charles Gibbs. I am a professor of anesthesiology, obstetrics and gynecology at the University of Florida College of Medicine, and assistant dean of curriculum there. I am a member of the Professional Liability Committee for the College of Obstetricians and Gynecologists.

Believe me when I say I am honored to be here today, and it is my privilege to be here today to discuss this very important issue of professional liability in general, and this bill in particular.

I am one, let me say at the outset, that believes that it is time for the Federal Government to look at this problem. It is necessary for the Federal Government to look at this problem. I am happy this committee is doing so. Let me tell you why.

I am from the State of Florida. The Florida Medical Association last year took what we thought to be a very reasonable proposal to our legislature. It was passed in the Senate and foundered in the House. Again, we took a more reasonable proposal this year to our legislature, and it got nowhere. We are assured it will get nowhere the next 2 years, as well.

Because of that, we are going to the people in the State of Florida and asking them to decide by way of constitutional amendment. I think it is a shame that we have to do this. However, this is the only way we stand a chance of getting anything accomplished. Therefore, I think it is reasonable that you provide direction to the States as to how to accomplish some of these goals.

As further evidence perhaps of the need for a national effort, I should point out to each of the members of the subcommittee that in all of their States, the size of the awards that have been awarded in the last year have increased in each of those States; and, in fact, in all of the States except one—that being North Carolina—the size of the awards are more than 10 percent greater than what would be expected on a national average. Therefore, there is a need for central direction.

You have heard several times today—and I suspect you will hear several more times—many facts and figures about the magnitude of the problem. Let me add a few of my own, if you will.

The number of claims have increased threefold in the last 5 years. One out of three physicians in Florida—up from one out of four—will be sued this year. Sixty percent of ob-gyn physicians in the country have been sued once. Twenty percent of them have been sued more than three times. And, for goodness sakes, 48½ percent of ob-gyn doctors in the State of New York have been sued more than three times. Now, you just can't believe—you can't tell me that you believe there are that many bad doctors in the State of New York and in the United States, especially when we live in a society and country known to provide the best medical care ever.

For example, maternal mortality is at its lowest point ever. It just can't be.

What about the cost and size of those awards? What about the cost of the claims? Even those that are dropped cost insurance com-

panies anywhere from $7,000 to $15,000. The average size of settlements, those without going to jury, the average is up around $120,000 now. Those that go to trial, it is around $900,000. The average award; that is staggering.

What kind of impact does this have on medicine? What impact does it have on the practice of medicine and the people of the United States? Physicians are changing the way they practice. They are changing it.

What about the doctor-patient relationship? They are passing those costs to the patient. They are practicing defensive medicine, and some are actually going out of business.

Look at those changes up close now. Can you imagine what the specter of malpractice must be hanging over the head of a physician or obstetrician in New York City, what effect that must have? Can you imagine what the tone in those offices must be? The traditional cherished doctor-patient relationship has to suffer.

You know, we wonder why physicians don't talk as much to patients as they used to. I think it is fairly obvious. They must feel that anything they might say can be used against them, as one of the reasons. That altered relationship is one aspect of the way the practice of medicine is being changed.

You know, physicians have to pay for this. Physicians have to pass these costs on. It is the cost of doing business. Forty percent of obstetricians have passed on anywhere from 10 to 30 percent in the last 2 years in raised fees just to cope with these increased premiums.

Defensive medicine, they do practice that. Physicians are doing more testing, more fetal monitoring, more consulting, more referrals, and that all costs money. For all those reasons, gentlemen, we need something done.

I, for one, am happy that you have presented this bill as an initial start. I think it is a good effort, along the right direction. Certainly, it will eliminate some of the outrageous claims and it will eliminate the long duration of time between claim and settlement. Those are good, good points that this bill addresses.

It will reduce court involvement. However, I guess you want some of my concerns. And I will summarize quickly.

We are concerned about the constitutionality. Does it really deny court access to patients?

We are concerned about the fact that it requires admission of responsibility, admission of negligence without really understanding and knowing what the cost of that is going to be. Those costs are to be decided in future proceedings.

Will it really decrease court involvement? Those settlements over $5,000 are mandated to go to court.

What about the dispute over the offered settlement versus the desired settlement?

We are concerned about the conflict between physicians and insurance carriers, and the conflict between physician and physician, physician versus hospital, when one physician joins another in a settlement. They have to work that out. But I wonder about that kind of conflict when it relates to the acceptance of this bill by physicians.

General damages, it will eliminate the outrageous costs. However, I wonder—there are such things as pain and suffering where there are no economic losses. I recognize there are those damages; for example, the lost eye or lost breast. Shouldn't we perhaps come up with some sort of a cap on general damages; provide some funds for pain and suffering; put a limit on it, if you wish, but perhaps give something?

Finally, do we really know what the cost is going to be? Are there any studies to indicate that?

Finally, I am going to say thank you again for allowing me to be here and listening to my remarks.

[The prepared statement and additional material follow:]

STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, PRESENTED BY CHARLES P. GIBBS, M.D., MEMBER, PROFESSIONAL LIABILITY COMMITTEE

Mr. Chairman, and members of the subcommittee, I am Dr. Charles Gibbs, Professor of Anesthesiology, Obstetrics and Gynecology and Assistant Dean for Curriculum for the University of Florida College of Medicine and a member of the Committee on Professional Liability of the American College of Obstetricans and Gynecologists. I am pleased to have this opportunity to address the Subcommittee on the pressing issue of medical professional liability and to speak to the pertinent points presented by H.R. 5400, the "Alternative Medical Liability Act."

The professional liability problem in the United States is one of epic proportions. It threatens to change irrevocably the scope and manner of medical practice, and to further escalate the already intolerable health care costs being borne by the nation. This is a fact that I believe most citizens—most patients—do not know. And so I applaud the Subcommittee and the Members who have taken bold steps to elevate this issue to national prominence, and to focus national attention upon what is clearly a national health policy issue.

I said that the problem is tremendous in scope; for a moment, allow me to illustrate:

Over 60% of Ob-Gyn's in the United States have been sued, a substantial number but certainly not a reflection of actual medical negligence;

Twenty percent have been sued three or more times;

In New York state, 48.8% have been sued three or more times;

The frequency of lawsuits has more than doubled for all physicians, while tripling for Ob-Gyn's—all in the last five years;

Between 1935 and 1975, over a period of forty years, fully 80% of the medical malpractice lawsuits were filed in the last five years of that period;

The sudden escalation of frequency of lawsuits has caused a rapid increase in premiums that physicians pay for insurance, a cost of doing business that is passed through to patients, and some physicians are now paying over $70,000 per year, which could add up to $300 to the cost of each delivery;

Average settlements now top $120,000;

Awards in trials now average $962,258.

As a result of the increasing frequency and severity of lawsuits, physicians are changing the way they practice. For obstetricians, one unfortunate consequence is that many are giving up obstetrics entirely. That will leave pregnant women in search of specialty care for the high risk pregnancies that are a significant portion of the 3.5 million births annually; patients will find care, but most likely in expensive, sometimes distant health centers, or from less qualified providers.

If they do not give up obstetrics, our own study has shown that a statistically significant number of Ob-Gyn's tend to do less high risk obstetrics, become more selective about which patients they accept, or how many, and they perform less gynecologic surgery. They perform substantially more diagnostic tests, at increased costs for patients and third-party payers.

The negative impact upon health care quality and cost is clear, and in fact may have more far-reaching impact than we can possibly assess at this point. Before the art of medicine is totally lost, we must respond with a coordinated, consistent policy. The states have attempted to deal with this issue on an individual, piecemeal basis, with little success. Several hundred state statutes have been passed and many declared unconstitutional or dismissed as ineffective, simply because there was no clear central policy or viewpoint at the heart of their efforts. We have had fifty sep-

arate and inconsistent efforts, and the lack of focus has led to today's disorganized and costly condition.

We appreciate the introduction of H.R. 5400 because it recognizes the need for a model for the states, and creates an incentive for them to follow the lead of the Federal Government. This medical liability problem is national in scope, specialists are held increasingly to a national standard of care, and so it is sidestepping the issue to pass off to the states the exclusive responsibility of fashioning a new method for responding to the threat posed by this issue. We think that you have before you an honest attempt to create such a new method, an attempt that represents the need and potential for improvement, but which does present significant questions. This bill proposes a radical departure from the status quo, and together we must examine the actual implications of its enactment.

The bill promises to provide for the payment—in a timely manner—of net economic loss. But the tender process is not clear, making it difficult to conclude whom—physician, hospital, or insurance company—would manage tender offers, and more specifically, how physicians could decide whether they should tender *any* offer. And no one has any reliable data on how much a no-fault, or quasi-no-fault, system might cost the nation.

The bill would also eliminate non-economic damages. This is important because it is this portion of awards or settlements that inflates in an unpredictable and unrealistic way the costs of liability. It is speculative at best. For that reason, from case to case amounts awarded for pain and suffering, loss of consortium, alienation of affection, etc., vary widely; and for that reason, the unpredictability forces insurance carriers to set higher and higher premiums. However, we have reservations about the fairness of this aspect of the bill and instead would propose limitations or caps on non-economic damages, rather than outright elimination.

The existing system is a gamble. Patients suing physicians can expect cases to last five years before any payment is seen, if at all. Attorney's fees are substantial. And of cases that do go to trial, physicians win the vast majority. So suing the physician is more an exercise in leverage, an attempt to "see what we can get", by playing time and threats against the defensibility of the physician's actions. This gamble occasionally pays off, and is quickly reported by the press, and that further encourages lawsuits. Instead of trying to solve the patient's health and financial dilemma, our current system is a lottery of sorts, occasionally paying off grandly, but usually not fairly compensating the patient.

Consider, for example, million-dollar verdicts. There were only 5 in medical malpractice cases in 1973. There were 20 in 1980 and 45 in 1982. The number of such cases continues to grow, while the quality of care is at its highest in history, with maternal mortality at its lowest point ever.

The Members of the Subcommittee certainly have reason for concern: million-dollar verdicts—in all personal injury cases, including both products liability and medical malpractice—total 5 in North Carolina, 10 in Tennessee, 11 in Indiana, 13 in Louisiana, 21 in Massachusetts, 63 in Illinois, and 219 in New York, a state which accounts for 16% of all million-dollar awards. And you are experiencing higher average awards overall than the rest of the nation: Illinois and Tennessee are 10% above the national average, Indiana is 15% above, Massachusetts is 19% above, and New York 21% above the national average for awards.

But this is not a regional problem, a state problem, nor one exclusively of this Subcommittee. It is a problem of national scope, requiring a national response. The only reason we cannot solve this matter by unilateral action at the Federal level is that unique state laws are involved, and in fact states should respect their citizens' particular circumstances. But they need a guide, and the Congress can assist in this effort. H.R. 5400 has certain provisions which will require further thought, and some testing in actual practice to see how effective or costly it might be, or even whether it is constitutional. But the Congress cannot stand by and allow this issue to continue percolating in the various states, continually escalating health care costs, forcing physicians to practice defensively, and alienating physician from patient. It is time for a national appreciation for the issue, a national concern, and a national policy focus that will both protect the interests of the patient and end the process of scapegoating the medical profession. I believe you are taking appropriately cautious and judicious first steps, but I also think the bill at issue needs some modification. Unfortunately, there is little time before irreversible damage will be done to medicine in America.

JUL 10 1984

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Please Reply to Writer at Address Below

Charles P. Gibbs, M.D.
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College of Medicine
Box J-215 J.H. Miller Health Center
Gainesville, Florida 32610

RECEIVED
JUL 1 , 1984
WAYS AND MEANS
HEALTH SUBCOMMITTEE

July 6, 1984

Honorable Andrew Jacobs, Jr.
Chairman
Health Subcommittee of
The House Ways and Means Committee
1533 Longworth House Office Building
Washington, D.C. 20515

RE: HR5400 - Alternative Medical Liability Act

Dear Congressman Jacobs:

On June 28, 1984 I was honored to present testimony on behalf of The American College of Obstetricians and Gynecologists regarding HR5400. However, because my testimony was limited to five minutes, I was unable to convey information that may be of further benefit to the Committee. Thus, I offer the following additional information, which was not contained in either my oral or written presentation.

First, relative to the need for the federal government to address this issue and provide direction for the states, you should be aware that there were no less than 15 bills introduced into the Florida legislature this year dealing with professional liability insurance. Not one of those bills passed. Also this year, The Florida Medical Association, after two years of frustration with our state legislature, is taking the issue to the public via a constitutional amendment. In my mind such experiences justify federal involvement, and I applaud your willingness to become involved.

Relative to the effect of the cost of professional liability insurance on the practice of medicine, there have been two recent pertinent Florida surveys. A Florida Obstetric and Gynecologic Society survey indicates that 29% of its members have given up the practice of obstetrics because the cost of professional liability insurance is so high. Another 25% intend to quit if relief is not forthcoming. One might think that the cost of

obstetric care might go down if patients chose other health care providers, for example, family practitioners or nurse midwives. However, a comparable survey performed by the Florida Academy of Family Physicians revealed that 44% of their membership have ceased obstetrical services because of the threat of malpractice and the cost of professional liability insurance premiums. Thus, the pregnant patient seeking professional obstetric care will have to travel long distances to medical centers where she will be treated by strange physicians and will deliver in a strange hospital. Or she will turn to less qualified personnel. (Copies of these two surveys are enclosed.)

Regarding the Bill HR5400 itself, perhaps the most important concern not addressed at the time of the hearing is the provision that allows renegotiation of the settlement at any time in the future. Surely, both physician and insurance carrier will be disturbed by this aspect of the bill. In effect, such a provision prohibits closure on a case. Thus, accurate predictions regarding cost are not possible. Moreover, uncertainty will remain on all sides creating the potential for endless legal haranguing.

Also, the bill requires that the physician admit responsibility without knowing the cost or liability of that admission. I would guess that both insurance carriers and physicians will be concerned about this aspect of the bill as well.

The sponsors of the bill indicate that court involvement would be less. Certainly, there is the potential for court involvement to be less. However, I wonder if such will really be the case. As stated in the bill, any settlement greater than $5,000 must be handled by the courts. Surely, most settlements will be greater than $5,000 because lawyer fees and other expenses will be added to the costs for medical care and economic losses. Also, any dispute between the amount offered by the physician or insurance carrier versus the amount desired by the patient and his or her attorney would need to be settled in court. I suspect that such disputes may be frequent.

The provision that expenses will be paid as well as economic loss may encourage minor claims that would not be considered viable today.

Another important concern, do we really know how much this proposal, if enacted, would cost? There are no previous studies for us to review. If the bill is acceptable and if everyone participates as envisioned, is there not a danger that the number of claims or settlements will be so great that the cost will be greater than what it is currently? In Florida this year, a true no-fault proposal was suggested by one of our Senators. Although the proposal was not passed, the legislature did appoint a 9-member

committee to study the issue and report back next year. Two hundred thousand dollars was set aside for this study. Perhaps, such a study could also be initiated at the federal level.

Finally, HR5400 is a good bill and offers a reasonable approach to a very difficult problem. Certainly, it would eliminate unreasonable awards as well as eliminate the "lottery" aspect of our current system. Furthermore, it would expedite proceedings which currently often take five to seven years. Also, the bill provides for payments over time rather than demanding lump sum settlement (court to decide). For all these reasons, I believe the bill to be useful, and I applaud the committee for conducting these hearings to address HR5400.

During the hearing Congressman Jacobs asked if a portion of the increased number of tests ordered under the guise of defensive medicine might represent tests ordered for personal monetary gain. The discussion that ensued did not answer the question. There is some evidence to indicate that such is not true. In a recent American College of Obstetricians and Gynecologists' survey, "Professional Liability Insurance and Its Effects: Report of a Survey of A.C.O.G.'s Membership," 80% of obstetricians had increased testing and other diagnostic procedures because of the threat of malpractice suits (Table 33 enclosed). In that same table it is noted that 79% of obstetricians now "document other miscellaneous activities" and 76% use more monitoring procedures, neither of which could result in monetary gain for the obstetrician; yet ordering these activities has increased to nearly the same extent as has ordering of tests. This information may provide some indirect evidence that the increased number of tests ordered is indeed inspired by the threat of malpractice litigation.

Again, thank you for allowing me to participate in the hearing. I hope this additional information will be of some value.

Sincerely,

Charles P. Gibbs, M.D.
Professional Liability Committee
The American College of Obstetricians
and Gynecologists

CPG:jc
Enclosures

Copy: Congressman W. Henson Moore
Congressman Richard A. Gephardt
Mr. Elvoy Raines
Ms. Bonnie Connors
Warren H. Pearse, M.D.
Ervin E. Nichols, M.D.

RELEASE

FLORIDA MEDICAL ASSOCIATION, INC.

Editor's note: The following News Release addresses the results of a survey recently conducted by the Florida Obstetric and Gynecologic Society regarding the effects of the professional liability problem in Florida on Obstetrical care. A detailed report and analysis of the survey will be included in the April issue of *The Journal of the Florida Medical Association, Inc.*

FOR IMMEDIATE RELEASE

March 8, 1983
Contact: O. William Davenport, M.D.
(305) 279-3773

MIAMI—Florida women may find it difficult in the near future to locate an obstetrician to deliver their babies because of the increasing number of doctors who are discontinuing this practice, according to a survey by the Florida Obstetric and Gynecologic Society.

The survey, conducted by O. William Davenport, M.D., of Miami, President of the Society, reveals that of the 423 obstetrician/gynecologists responding to the questionnaire, 25% reported they have stopped the delivery of babies. Another 29% of the physicians who contique this practice are considering giving it up in the near future, according to the survey.

The number one reason given for discontinuing or planning to discontinue this practice is the state's medical malpractice problem which has resulted in spiraling malpractice insurance premiums and the increasing likelihood of doctors facing costly, traumatic court suits, the survey shows. Today, one out of every four Florida physicians will be involved in a malpractice claim during the next twelve months.

"Unless conditions improve I fear that all of the advance technology such as fetal monitoring, anesthesia and sterile techniques, which over the past half century have brought women from the kitchen table to the hospital for childbirth, will be abandoned," Dr. Davenport commented.

"I anticipate more deliveries by non-physicians as a result —it's sad," was the comment of one doctor participating in the survey.

"I am tired of living under the sword, wielded by a pack of blood-thirsty, ambulance-chasing lawyers," another doctor commented. "Awards and premiums are utterly ridiculous."

Another obstetrician said he was still delivering "but getting paranoid about it." Still another said he was practicing "fearfully and defensively."

According to the Florida Physicians' Insurance Reciprocal (FPIR), which insures more than 5,000 doctors for malpractice, the premium for an obstetrician/gynecologist practicing in Dade and Broward counties is $27,000 annually for the $500,000 minimum coverage. For the maximum $6.5 million coverage, the annual premium is $53,200. If the doctor discontinues his practice of obstetrics, the average premium decreases to $18,500 for the minimum coverage and $37,000 for the maximum.

Ninety-three percent of the respondents said they are insured for professional liability and, of those who indicated they are not, 70% said they dropped coverage because the premium was too high.

Currently, there are 38 claims pending against obstetricians in excess of a million dollars for allegedly brain damaged infants, an FPIR spokesman said.

Of the 696 questionnaires mailed in February, 423 were returned, a 61% response. The survey consisted of five questions but additional responses were volunteered from approximately 100 of the physicians.

(continued on next page)

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"The survey indicates that the current professional liability problem is having a definite impact on the practice of obstetrics in Florida," Dr. Davenport said. "It will also adversely affect the practice of obstetrics in the future if it is not resolved."

Obstetrician/gynecologists who have discontinued deliveries are engaged in routine gynecological care and transferring their pregnant patients to other doctors who still practice obstetrics.

Although some respondents listed age, health and other personal reasons for discontinuing the practice of obstetrics, 63% said they gave up this practice because of the high risk liability problem.

Other comments from doctors who have stopped or plan to stop this practice were:

I ceased delivery of obstetrics in late 1976 at age 38 anticipating all the problems we now face. I continue to pay the full OB/GYN premium but will cease that if there is another increase in premiums.

Increasing difficulty meeting some patients' demands, guarantees for successful outcome, etc.

Dislike the atmosphere we are put in by the legal profession . . . .

Possibly, depends on what happens this year. If premiums keep rising I will be forced out even though I love obstetrics and desire to continue it.

I would love to stop because of absurdly high premiums. However, I have only been in practice for a few years and at least 70 percent-plus of my practice is obstetrics. I can't afford to continue, neither can I afford to stop.

I consider it impossible to continue the practice of obstetrics with the fear we all have that any unexpected poor outcome will end up in a lawsuit. Obstetrics is not an exact science. I cannot guarantee all my patients will have 100 percent good results—it doesn't matter how well trained I am!

I wish I could stop. The increasing risk of taking care of obstetrical patients has taken the joy out of what once was one of the most rewarding areas of my practice—it's not worth the risk anymore.

It's hard to pay those high premiums when I do 4-8 deliveries a month now.

Two sons in medical school—they were thinking of joining me but will now go to dermatology and radiology.

My son, who is in practice with me, does not deliver babies mainly because of the malpractice crisis.

We must do a better job in educating the public about the causes of brain damage and retardation. We need to erase their reflex response that it must've been malpractice.

SPECIAL ARTICLE

A survey on effects of malpractice insurance premiums on delivery of health care in family practice

Guy T. Selander, M.D.

This article, authored by Guy T. Selander, M.D., President of the Florida Academy of Family Physicians, regarding the survey of current medical practices among family physicians, is another clear indication of the effect that the threat of medical malpractice suits is having on Florida physicians.

This survey, along with a similar one by the President of the Florida Obstetric and Gynecologic Society previously published in the April 1983 issue of *The Journal of the Florida Medical Association*, leaves no doubt that the availability of health care for Florida residents is being seriously affected. Only meaningful tort reforms can reverse this trend of physicians limiting their practice, thus deleting the more hazardous procedures, as well as the expensive practice of defensive medicine.

James W. Walker, M.D.
President, PIMCO

This survey was conducted in April and May of 1983 by the Florida Academy of Family Physicians in order to determine the effects of medical malpractice insurance premiums on the delivery of health care in Family Practice. The results reveal that family physicians are curtailing their services as a direct result of the current medical malpractice crisis. Forty-four percent of the responding physicians will cease their obstetrical services, an area which is already being limited by the obstetrical specialists, and 30 percent will discontinue hospital surgery. In addition, the physicians pointed out that hundreds of additional dollars are being spent on x-rays, laboratory studies and extra days of hospitalization and consultations as a result of this problem.

Ninety-eight percent of the respondents to the survey said they are insured for professional liability. Of those who said they are not, 75 percent said it was because premiums are too high.

This survey indicates that the current professional liability problem is having an adverse effect on the practice of Family Medicine and on the availability and affordability of health care to the citizens of Florida.

The Author
GUY T. SELANDER, M.D.
Dr. Selander is President of the Florida Academy of Family Physicians, and practices in Jacksonville.

Overview • This survey was conducted by the Florida Academy of Family Physicians to examine the effects of malpractice insurance premiums on the delivery of health care in Family Practice via a mailed questionnaire. The results of the questionnaire survey are summarized in this report.

Methods • The data presented here was collected in a mail questionnaire survey of the active members of the Florida Academy of Family Physicians. Surveys were mailed on April 15, 1983. Responses received through May 18, 1983 are summarized.

Of the 1,073 questionnaires mailed, 497 were returned, a 46 percent response rate.

The questionnare consisted of six questions to be answered by checking off alternative answers or filling in a response. Respondents were not required to identify themselves, but were asked to name the county in which they practice.

Results • *A. Services performed in the full practice of Family Medicine* — Respondents were asked whether or not they included five different services in their full practice of Family Medicine, or whether they were ever included in their practice. The results are listed in Table 1.

Table 1.—Services Performed in The Full Practice of Family Medicine

	Yes	No	Never Included
Hospital Surgery	8%	30%	59%
Office Surgery	76%	13%	10%
Assisting in Surgery	16%	39%	42%
Obstetrics/No Surgery	6%	44%	46%
Plastic Surgery	3%	30%	63%
Obstetrical/Gynecological Surgery	4%	33%	59%

B. Reasons for discontinuation of special procedures — Respondents were asked their reasons for discontinuing special procedures. Many physicians had more than one reason, therefore, percentages of reasons shown in Table 2 exceed 100 percent.

Table 2.—Percentage of Reasons for Discontinuation of Special Procedures (for 288 physicians who responded)

The High Risk Liability Problem	91%
Personal Reasons	17%
Other	5%

"May stop assisting. Just doesn't pay enough to cover the increased malpractice premiums. And I've never been sued."

C. Opinion as to receipt of medical services by patients when practice is limited — Respondents were asked where patients may receive medical services if they limited their own practices. Many of the respondents had at least two responses to this question, therefore, percentages in Table 3 exceed 100 percent.

Table 3.—Percentage of Opinions as to Receipt of Medical Services By Patients If Respondents Limit Their Own Practices (for 375 physicians who responded)

From Colleagues in My Practice	26%
From Other Physicians	84%
From Midwives	6%
Other	4%

"Six out of eight (four family practitioners) who do obstetrics in (my town) are giving it up this year. The remaining Obstetricians do not accept new cases."

D. Carry professional liability insurance and reasons for not carrying professional liability insurance — Respondents were asked whether or not they carry professional liability insurance. Ninety-eight percent of the respondents said they do.

Respondents who said they do not carry professional liability insurance were asked their reasons. Some of the respondents had more than one reason, therefore percentages shown in Table 4 exceed 100 percent.

Table 4.—Percentage of Reasons for Not Carrying Professional Liability Insurance (for 12 physicians who do not)

Premiums Too High	75%
Other	25%

"I have had to quit obstetrics and vasectomies and assisting in surgery due to malpractice insurance costs."

E. Estimated cost increase due to practicing defensive medicine — Respondents were asked to fill in the estimated cost increase (dollar amount) and the estimated percentage increase due to practicing defensive medicine for four different types of common symptoms treated by family physicians. An "other" space was also provided with a blank line to be used for a description. Written into this space were: depression — subtle; trauma; emergency; obstetrics; routine office visit; fever; blood count, and biopsy. The responses to this question have been averaged in Table 5.

"Minimum three days critical care unit at hospital at $525 a day. Formerly would have observed at home."

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Table 5.—Estimated Cost Increase Averages Due To Practicing Defensive Medicine

	Average Cost Increase	Number of Respondents	Average % increase	Numb Respo
G.I. Disturbance	$276	86	95%	2
Chest Pain	$542	86	53%	2
Headache	$375	84	58%	2
Auto Accident	$404	72	16%	2
Other	$324	8	70%	

F. Percentage of consultations for own protection — In the final question, respondents were asked to fill in what percentage of consultations obtained are for their own protection. The average of the responses was 37 percent. The answers ranged from 0 to 100 percent.

Family Physicians, like their colleagues in other specialties, find themselves more and more looking over their shoulders for that lawsuit, as they attempt to conscientisouly care for their patients. The end result is higher cost to the patient, because of defensive medicine, and because s times the qualified family physician refers many of the cases he used to ca to another specialist, in order to sprea risk.

If legislative relief is not forth-con the public must be awakened to the that this is not a "doctors versus law issue, but one that very seriously conc them and the caliber of the health care receive.

• Dr. Selander, 1736 University, Blvd. S., Jackso 32216.

PROFESSIONAL LIABILITY INSURANCE AND ITS EFFECTS: REPORT OF A SURVEY OF ACOG's MEMBERSHIP

Prepared by:
Porter, Novelli & Associates
August 31, 1983

Table 33

PERCENT RESPONDING THAT INCREASE IN MALPRACTICE SUITS INCREASED SPECIFIC ACTIVITIES IN PRACTICE, BY NUMBER OF TIMES SUED

	TOTAL	Number of Times Sued			
		0	1	2	3+
Testing and other diagnositc procedures	83.3%	79.7%	83.0%	83.7%	88.6%
Document other miscellaneous activities	78.7	76.6	79.8	76.7	81.8
Monitoring procedures	77.5	73.7	76.9	78.8	83.0
Obtain written informed consent	67.0	68.1	65.0	67.5	68.1
Consultations with other physicians	63.3	59.4	62.4	65.3	68.8
Provide written or taped information to patients	54.9	50.4	56.5	53.6	60.0
Referrals to other physicians	51.0	46.9	47.7	54.5	59.3
Staff presence at exams	23.2	23.1	22.1	22.8	25.6

Mr. MOORE. Thank you, Dr. Gibbs.

We will submit all the statements for the record, of course, as the chairman said.

We appreciate your being here.

Mr. Kent Brown.

STATEMENT OF KENT MASTERSON BROWN, GENERAL COUNSEL, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC.

Mr. BROWN. Thank you, Congressman Moore.

Let me first of all state that the Association of American Physicians and Surgeons is truly privileged and pleased to be here and to be invited to participate in this panel with these other august associations of physicians.

Let me also, as our written statement states, commend you and Congressman Gephardt for the work you are doing and have done in not only developing H.R. 5400 but especially for making this part of what appears to be almost a public awareness program in terms of medical liability and insurance matters in this country. They are great and do need exposure, and this is a spectacular way, in our mind, of getting that exposure.

We commend both you and Congressman Gephardt for your work in this matter.

With respect to H.R. 5400 in particular, the association does not have any formal position one way or the other at this hour as to that bill. We do have some concerns, and it is those concerns that I am here to summarize for you. Again, we have submitted a written statement and, thus I really more or less want to summarize our position as opposed to read any statement.

First of all, with respect to the underlying cause of the medical liability problem in this country—and, indeed, in some regions of this Nation it is a problem; in other regions it is not—being a lawyer myself, I am amazed many times at the thoughtfulness of juries and how well the civil court system does work. I think for the few major claims that we see reported in the headlines, we do not see the hundreds and hundreds of claims that juries reject, or, those claims which simply don't go anywhere in the civil court system. I think we should recall those today as well, and we should remember them; and that the civil court system does work with justice.

With respect to the underlying cause of what problems we see in medical liability around the country, let me state that we are dealing with a medical delivery system that has been the recipient of massive infusion of third-party moneys. It is unlike any other economic order in this country. Because of that, it has become immensely inflationary.

I state this because I believe that this massive infusion of funds into the economic system of health care has driven a wedge between the physician and his patient, and has created a disincentive for the physician to develop meaningful relationships with his patients. And, because of that breakdown, because of what the patient perceives as a breakdown between him and his physician, it has made the medical liability route seemingly something more attractive.

In order to address whether or not we are going to see more medical liability lawsuits in the future, we should do something with respect to that payment system and not make it so readily available, but make that patient a little more financially responsible and make the physicians in turn have incentive to develop a greater and more meaningful relationship with his patients.

With respect to the bill, H.R. 5400, let me state that the concern the association has is a constitutional one. It boils down to the one provision that was discussed this morning; that is, whether or not the potential defendant in a potential civil litigation can turn to the potential plaintiff and tender some offer of economic compensation and shut off that potential plaintiff's access to the courts.

It was brought out in very pointed terms when the distinguished professor from the University of Virginia addressed this body, and he said for purposes of those patients who have very large noneconomic losses but very small economic losses, they may be the ones who simply fall through the system.

I maintain that the civil court system is there to protect precisely those people, and we are concerned that maybe H.R. 5400 may create a greater problem among those people seeking the smaller losses who otherwise probably would never go to the civil courts, and yet mandate those with enormous noneconomic losses but small economic losses to be denied everything.

For those people, as well, we must remember that with the enormous prevalence of disability insurance and health insurance in this industry, that their economic losses may be negligible, may be nothing; and yet, their noneconomic losses may be enormous. And, for them, they fall through the system.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF KENT MASTERSON BROWN, ESQ., GENERAL COUNSEL, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC.

SUMMARY

The Association of American Physicians and Surgeons is different from any other association representing providers of medical care. It has always relied upon certain fundamental constitutional principles and precepts as the basis for its political positions. Therefore, its members have always favored less federal legislation and control in all segments of the American economy, not only the health care field. These positions are marked by an unselfish yearn for the greater political good of the nation, not a selfish urge to take for its members a piece of the federal dollar or reserve for its members a share of the bureaucratic malaise. In this light the Association of American Physicians and Surgeons is the only association whose concerns transcend the self interest of doctors and extend to a concern for the maintenance of fundamental rights and prohibitions embodied in the nation's organic law.

The Association of American Physicians has not taken a formal position on H.R. 5400, the Alternative Medical Liability Act, but has certain concerns which must be expressed. Although the threat to physicians of medical malpractice litigation is a very real one, the Association would suggest that the threat has its cause in the breakdown of patient-doctor relationships brought about by the interjection of government and other third-party payments for health care services. Only a government withdrawal from the health care business, and the evolution of a competitive health care market will remedy the cause of the malpractice litigation problem.

The Association's fundamental concern with H.R. 5400 is a constitutional one. Although the members are impressed by the proposal's attempts to remove the time, grief, uncertainty and costs involved in the traditional malpractice case, they are more worried about undermining a citizen's basic right of access to the courts. Critical in the proposed legislation is the power of the provider, not the patient, to trig-

ger the alternative recovery system and the corresponding loss of the patient's access to the courts. Insofar as H.R. 5400 gives the potential defendant such crucial power, it potentially violates the guarantees embodied in Article IV, Section 2 and the Fifth Amendment to the U.S. Constitution. Insofar as the States adopt the proposal by legislation it potentially violates the Fourteenth Amendment.

The Association would like to selfishly endorse the proposal. Here, however, the Association must put the greater good in advance of its more narrow economic interests. There may be some selfish motives in this position as well: if access to the courts is denied to patients, then it may be denied to physicians as well.

The potentially constitutional-offending portion of H.R. 5400 would be remedied by making the denial of access to the courts subject only to the agreement of the injured patient, therefore avoiding conflict with the nation's organic law.

The Association of American Physicians and Surgeons firmly believes that the problem of medical malpractice litigation will adjust itself if the system of third-party payment is adjusted, and, more importantly, if natural market competition becomes the law of the health care marketplace, and physicians, as individual competing professionals, have the incentive to develop meaningful, professional relationships with patients.

STATEMENT

The Association of American Physicians & Surgeons is privileged to participate in these discussions regarding H.R. 5400, the Alternative Medical Liability Act, and I, as General Counsel of that Association, am especially privileged to offer the Association's corporate thoughts and concerns regarding H.R. 5400.

The Association of American Physicians & Surgeons cannot be likened to any other association representing providers of medicine or health care. Since 1943, the year of its founding, the Association of American Physicians & Surgeons always has relied upon certain, fundamental consititutional principles and precepts as the basis for its political positions. Concepts embodied in the constitutional term "republican form of government", for instance, have long motivated the members of the Association in lobbying for less federal legislation and control in not only the health care field but all other segments of the American economy. Those positions taken by the Association have been marked by an unselfish yearn for the greater political good of the nation not a selfish urge to take for its members a piece of the federal dollar or reserve for its members a share of the bureaucratic malise. In this light the Association of American Physicians & Surgeons is the only association the concerns of which transcend the self interest of doctors and extend to a concern for the maintenance of fundamental rights and prohibitions embodied in the nation's organic law.

The Association of American Physicians & Surgeons commends Congressmen W. Henson Moore and Richard G. Gephardt for not only the sincere concern they have show in regard to issues which confront the health care delivery system today, but for their sincere sensitivity to the concerns of those who are affected by both the issues discussed and the remedies Congress proposes and enacts. The Republic is well served by such statesmen.

The Association of American Physicians & Surgeons has not taken a formal position on H.R. 5400, The Alternative Medical Act, but does have certain concerns which must be expressed for purposes of discussion. Though the threat of medical malpractice litigation to physicians is a very real one everywhere, the Association would suggest that that threat has its cause more in the breakdown of physician-patient relationships and confidences brought about by the interjection of massive third-party (including government) payments for health care services. There is a disincentive in the health care marketplace for physicians to take the time to develop meaningful, professional relationship with patients. In addition, with the massive infusion of third-party (including government) payments for health care services, medical practitioners have been on the receiving end of the longest-sustained and highest inflationary spiral of any segment of the American economy. That alone has caused a near irreparable loss of confidence in and respect for providers of health care services by patients.

Only a government withdrawal from the massive underwriting of health care services, and an evolution of a more naturally competitive health care market will remedy the cause of the malpractice litigation problem.

The fundamental concern of the Association of American Physicians & Surgeons with respect to H.R. 5400 is a constitutional one. Though the members of the Association are moved by the proposal's attempt to remove the time, grief, uncertainty and costs involved in the traditional malpractice case, they are more worried about undermining a citizen's fundamental right of access to the courts of the land. Under

H.R. 5400 providers of the health care services have the option to escape potential liability for "non-economic losses." If the provider makes an offer to pay the aggrieved patient's "economic losses," the patient loses his or her ability to sue under the current tort system. By escaping the current tort system, the provider avoids potential liability for "non-economic damages," such as pain and suffering, punitive damages, loss of consortium and a host of other potential, special damages. Critical in the proposed legislation is the power of the provider, not the patient, to trigger the application of the alternative recovery system and the corresponding loss of the patient's access to the courts. Is legislation which permits that to occur consistent with the nation's organic law? The Association of American Physicians & Surgeons believes that it is not.

Insofar as H.R. 5400 leaves the power to trigger the alternative payment system to the provider—the potential defendant—it potentially violates the guarantees embodied in Article IV, Section 2, and the Fifth Amendment to the Constitution of the United States. Insofar as the States adopt the proposal by legislation it is potentially violative of the Fourteenth Amendment.

I. ACCESS TO THE COURTS IS A PRIVILEGE INHERENT IN NATIONAL CITIZENSHIP

According to Article IV, Section 2, of the United States Constitution, "The Citizens of each State shall be entitled to all Privileges and Immunities of Citizens in the several States." Out of Article IV, Section 2, of the Constitution the Courts have crafted through the years the "privileges and immunitities" of citizens. As it is a federal Constitution which the courts intepreted, the "privileges and immunities" which were protected therein were those which emanated from National citizenship.

The right to institute a civil action—the so-called "right to justice"—is as old in the English-speaking world as Magna Charta, and has been guaranteed in the Federal Constitution. The Supreme Court of the United States has stated that there are certain attributes of citizenship which are, "in their nature, fundamental, and which have, at all times, belonged to the citizens of the several states which compose the Union." *Corfield* v. *Coryell*, 4 Wash. CC 371 (U.S. Cir. Ct., E.D. Pa., 1825). Such rights may be "comprehended under the following heads:

". . . protection by the government; the enjoyment of life and liberty, with the right to acquire and possess property of every kind, and to pursue and obtain happiness and safety, subject nevertheless to such restraints as the government may justly prescribe for the general good of the whole. The right of a citizen of one state to pass through and reside in any other state, for purposes of trade, agricultural, professional pursuits, or otherwise; to claim the benefit of the writ of habeas corpus; *to institute and maintain actions of any kind in the courts of the state;* to take, hold and dispose of property, whether real or personal . . ." (Emphasis added.)

The holding in *Corfield* v. *Coryell, supra.*, was specifically directed to the rights of citizens of one state passing into another, or, in other words, the "privileges and immunities" guarantee in Article IV, Section 2, of the Federal Constitution. The holding forms the backdrop to those "privileges and immunities" protected in the Fourteenth Amendment, and guaranteed to the citizens of the United States residing in a particular state. Since the decision by the Supreme Court of the United States in the *Slaughter-House* cases, 16 Wall. 36, 74 (1873), "privileges and immunities protected by the Fourteenth Amendment have been, largely, those which owe their existence to the Federal Government, its National Character, its Constitution, or its laws." "Access to courts of justice in the several states," in the *Slaughter-House* cases, *supra.*, was enumerated by the Court as a "privilege and immunity" emanating from National Citizenship.

The Association of American Physicians & Surgeons believes that such a privilege—the right to justice—does emanate from National Citizenship and must not be disturbed.

II. ACCESS TO THE COURTS IS ESSENTIAL TO THE GUARANTEE OF DUE PROCESS OF LAW AND THE EQUAL PROTECTION OF THE LAW

Under the Fifth Amendment to the Constitution of the United States, "No person shall . . . be deprived of life, liberty, or property, without due process of law." The Fourteenth Amendment applied the requirement to provide due process before one's life, liberty or property may be denied directly to the States, adding, as well, the proscription against the State's infringing upon fundamental "privileges and immunities" embodied in Article IV, Section 2. The Fourteenth Amendment reads, in pertinent part, at Section 1, "No State shall make or enforce any law which shall abridge the privileges and immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor

deny to any person within its jurisdiction the equal protection of the laws." "Due process of law" is an essential Constitutional guarantee.

The "right to justice" is essential to the constitutional guarantee of "due process of law" and the "equal protection of the laws." Part of "due process" is the guarantee of reasonable access to the courts. *National Ass'n. for the Advancements of Colored People* v. *Harrison*, 360 U.S. 167 (1958). *Mullane* v. *Central Hanover Bank & Trust Co.*, 339 U.S. 306 (1950). It can safely be said from our constitutional jurisprudence that unreasonable restraints upon the right of access to the courts will be held violative of due process of law and unconstitutional. *Cohen* v. *Beneficial Industrial Loan Corp.*, 337 U.S. 541 (1949); *Cotting* v. *Kansas City Stock Yards Co.*, 183 U.S. 79 (1901).

In the past, Courts have dealt somewhat harshly with "restraints" or "barriers" to access to the Courts. Ex parte Young, 209 U.S. 123 (1908). Here, there is a potential denial altogether of one's right to protect his person and property by resort to the civil courts. Such, the Association submits, may well elevate such a proposal to one which, in the words of the Supreme Court, is so "arbitrary, unequal and oppressive" as to "shock the sense of fairness the Fourteenth [and Fifth] Amendment[s] [were] intended to satisfy. . . ." *Chicago & N.W.R. Co.* v. *Nye Schneider Fowler Co.*, 260 U.S. 35 (1922).

Due process of law embodies the fundamental "right to be heard." *Schroeder* v. *New York City*, 371 U.S. 208 (1962). H.R. 5400, the Association submits, would strip from patients all "rights to be heard." It would strip a patient of his or her property—his or her choses in action—without affording him or her at any time an opportunity to be heard. It would deny the patient the only remedy to secure long-recognized elements of damage by the potential defendant simply making an offer of economic compensation. Such would be constitutionally difficult of justify. *Brinkerhoff-Faris Trust & Sav. Co.* v. *Hill*, 281 U.S. 673 (1920).

Additionally, the constitutional guarantee of "equal protection of the laws" simply would not permit legislation which would deny certain persons access to the Courts for injuries to person or property or insulate another group of persons from civil liability. The equal protection clause historically has embodied "like access to courts of the country for the protection of . . . persons and property, the prevention or redress of wrongs, and the enforcement of contracts," *Barbier* v. *Connolly*, 113 U.S. 27, 31 (1884).

Truly, the Fifth and Fourteenth Amendments to the Federal Constitution would be offended by H.R. 5400 and its subsequent state-enacted legislative descendants.

CONCLUSION

The Association of American Physicians & Surgeons is pleased that the proposed H.R. 5400 seeks to relieve its medical practitioner members from the burdens of medical malpractice litigation. There are heavy burdens in the current tort system to be sure. The members of the Association would like to selfishly endorse the proposal in its entirety. Here, however, the Association must put the greater good in advance of its more narrow economic interests. To be sure, there may be some selfish motives in this stand, for if access to the courts of the land is denied to patients, then it may be denied to physicians as well.

A remedy to the potentially constitutional-offender portion of H.R. 5400 would be to make the denial of access to the Courts subject only to the agreement of the injured patient. In such a manner, any conflict with the nation's organic law would be avoided.

With respect to the greater issue—medical malpractice litigation—the Association of American Physicians & Surgeons firmly believes that it will adjust itself if the system of third-party payment is adjusted and, more importantly, if natural market competition becomes the law of the health care marketplace, and physicians, as individual competing professionals, have the incentive to develop meaningful, professional relationships with patients.

STATEMENT OF DONALD H. STEWART, JR., M.D., PAST PRESIDENT, CONGRESS OF NEUROLOGICAL SURGEONS, ON BEHALF OF THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS AND THE CONGRESS OF NEUROLOGICAL SURGEONS

Dr. STEWART. Mr. Chairman, I am Donald Stewart. I am a practicing neurosurgeon in Syracuse, NY. I appreciate the invitation to come here to give testimony on behalf of the 3,000 neurosurgeons

in the country. I don't want to read the formal statement which you have, but just make a few comments.

The premium neurosurgeons in New York City pay is $63,000, which is about what the Government pays you for a year's work. We understand that malpractice embodies a concept of an improper professional action or treatment by a physician, as from reprehensible ignorance or neglect, or with criminal intent. We don't condone malpractice, and we know it occurs.

We believe in sanctions against those guilty of it. We believe in proper restitution to the victims. We believe that the insurance system that presently allows 20 or 30 percent of the premium to reach the injured party, and 70 percent to pay the overhead, really needs some careful review.

It is our understanding that the plaintiffs' and defendants' attorneys together get more than twice as much than the injured party. We believe that the true victims of the system are the public that pay the premiums.

We are glad that this assembly, this Congress, is reviewing this matter because of the high costs of defensive medicine. We support many of the concepts in the bill.

We think that there should be a more accurate definition of "malpractice." We believe the definition should differentiate between malpractice as opposed to a therapeutic misadventure or, as Professor O'Connell said, the natural sequela of the disease process.

We are worried that if everybody is compensated for every illness, that the costs will be very high. We think that it wouldn't be unreasonable to require higher degrees of proof of malpractice than presently exist.

We very much like the idea of elimination of awards for pain and suffering—that concept has been implemented into law by the Canadian Supreme Court—for the same reasons that Professor O'Connell alluded to.

We like the concept of structured awards.

Finally, as one suggestion or comment, Mr. Chairman, we think it would not be unreasonable to provide in the bill a definition of a reasonable attorney's fee. If it were included, it would make the philosophy and the action of the Social Security Administration, with respect to all professions, somewhat consistent and more even.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF DONALD H. STEWART, JR., M.D., PAST PRESIDENT, CONGRESS OF NEUROLOGICAL SURGEONS, ON BEHALF OF THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS AND THE CONGRESS OF NEUROLOGICAL SURGEONS

ABSTRACT

We support the following concepts and recommendations.

There should be an accurate definition of malpractice differentiating between malpractice as an act of poor performance as opposed to a therapeutic misadventure.

It should require higher degrees of proof of malpractice than presently exist in the courts.

Provision should be made for rapid restitution to those truly injured.

It should encourage settlements to be made outside the courtroom.

Compensation should be encouraged on a logical basis but a cap should be fixed on, or a provision made for the elimination of emotionally determined awards for

non-measurable, non-economic losses, such as pain and suffering or loss of consortium, etc.

It should encourage structured awards which would replace the economic losses suffered.

A coordination of collateral benefits should be mandated so that duplicate reparations are not made for one event from several sources at double or triple the cost of replacing the measured economic losses.

It should provide for the reduction of frivolous suits.

It should stipulate a limitation on the fees charged by attorneys.

It should allow awards to be taxed by the Federal Government or mandate that they be reduced to the extent that taxation would reduce the award if it were not to be taxed.

STATEMENT OF THE WASHINGTON COMMITTEE OF THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS AND THE CONGRESS OF NEUROLOGICAL SURGEONS ON H.R. 5400, THE ALTERNATE MEDICAL LIABILITY ACT, JUNE 28, 1984

Mr. Chairman: Thank you for the invitation to offer testimony for organized neurological surgery on H.R. 5400 "to amend Part A of Title XVIII to provide for an alternative liability system for medical malpractice in the case of injuries under Medicare and other federal programs if states fail to provide alternative liability systems".

I am Donald H. Stewart, Jr., Past President of the Congress of Neurological Surgeons and a practicing neurosurgeon in Syracuse, New York.

There are over 2,800 practicing neurosurgeons in America, all of whom have a deep interest in professional liability insurance reform. H.R. 5400 is particularly important to us because it raised issues at the national government level that have been previously debated in many state jurisdictions, unfortunately, without much action. The current "crisis" is real and demands national solutions to many of the issues addressed in the legislation under discussion here today. To succeed, all parties must understand the gravity of the problem and structure legislation that will minimize abuses while protecting the rights of individuals who are victims of malpractice. We know the task before you will be difficult but be assured, Mr. Chairman, we are prepared to assist in this important reform effort.

The following statements summarize our general philosophy regarding malpractice which is defined in the dictionary as "an improper profesional action or treatment by a physician, as from reprehensible ignorance or neglect or with criminal intent":

We do not condone malpractice.

We recognize that it occurs.

We believe in professional and economic sanctions against those guilty of malpractice.

We believe in proper restitution for those individuals who are victims of malpractice.

We believe it is socially responsible for physicians to insure against the possibility of a malpractice occurrence to protect those whom they treat as well as themselves.

We believe that the distortions in the medical liability insurance system are similar to those in the general liability insurance system.

We believe that the cost of society at large to provide for itself liability insurance for all types of liability is enormous and indeed continues to escalate year after year. We believe that this is not understood by the public which funds this insurance system.

We believe that the insurance system that has been established to provide the protection and restitution to the involved parties has been distorted. It does not resemble the structure that it was intended to be or should be.

We believe that any insurance system that allows a total of 20–30% of the premium paid to reach the injured parties is seriously in need of careful, thoughtful review and reform; 70% of the dollars provided by medical liability premiums support system overhead rather than the injured party. This in itself warrants careful examination.

We believe that the data support the statement that defense attorneys receive more of the premium dollar than plaintiffs' attorneys, and that both together receive more than twice as much from the system as the original intended beneficiary.

We believe that our society has become more litigious and has developed a "risk-free" mentality with no desire to examine the question of the impact of the total cost to society for regarding a relatively few individuals with, in many instances, astronomical settlements. Those few recipients, in turn, seemingly gladly give to

their legal advocates 30–50% of the total award. Perhaps Abraham Lincoln was anticipating our problems when he said, "Discourage litigation. Persuade your neighbors to compromise whenever you can. Point out to them how the nominal winner is often a real loser—in fees, expense and waste of time".

We believe that the true victims of the present medical liability insurance are indeed those who pay the premiums and that the beneficiaries of the present system, unfortunately, all too often, are not those injured.

We believe that the "risk-free" mentality has produced an insurance mechanism that condones the dislocation of large sums from society as a whole for the beneift of a relatively few individuals who, under the guise of administering justice, reap the benefits of the distorted insurance reparation system.

We believe that the level of public awareness and knowledge of the intricacies and facts related to liability insurance, and to medical liability insurance specifically, is so low as to make it impossible for social/legal reforms to come from the 50 states. Such has been the case in recent years in New York, Florida, and California.

We believe that it is time that the National Legislature seriously consider reform for federally-funded programs. We believe that such action will give a chance for the rebirth of the principles of fairness and equity upon which the insurance system was originally founded.

Mr. Chairman, the stakes are very high. It has been estimated that the cost of defensive medicine represents 30% of the Federal Government's health care outlays. The cost of the insurance premiums for our specialty in New York State is as high as $63,000 per neurosurgeon. This approximates what the U.S. Government and its people pay for a year's work. Since it is an allowable cost, it impacts on the cost of care to the people of our country. It is particularly important that the question of societal cost be related to this problem at a time when initiatives to reduce costs are being considered by the President and Congress.

We support the following concepts and recommendations which would apply to a reform of the system we are discussing today. These recommendations, if implemented, should:

accurately define malpractice and differentiate between malpractice as an act of poor performance as opposed to a therapeutic misadventure, such as a recognized complication.

require higher degrees of proof of malpractice than persently exist in the Courts, and similar to but not as severe as those required for proof of criminal action.

rapidly provide for restitution to those truly injured (the average time for final settlement of a case after malpractice has occurred is 8 years).

encourage settlements to be made outside of the heavily crowded, cumbersome and expensive courtroom arena.

encourage compensation on a logical basis but fixing a cap on or eliminating emotionally determined awards for non-measurable, non-economic losses, such as pain and suffering or loss of consortium, etc. The Canadian Supreme Court has fixed a maximum allowance for this which they eloquently stated was "in the best interests of all the people of Canada".

encourage structured awards which would replace the economic losses suffered. Payment would be made throughout the future rather than permitting one-time awards for projected future losses. Should such a structured award program be implemented, then the intent of those deciding the measurable future economic losses of the injured party would be realized.

mandate a coordination of collateral benefits so that duplicate reparations are not made for one event from several sources at double or triple the cost of replacing the measured economic losses.

reduce frivolous suits (53% of the suits brought in medical liability cases are dropped without payment of any kind—but these cases cost a considerable amount even to defend).

specifically limit the fees charged by attorneys to sums which would be considered reasonable by any prudent person.

allow awards to be taxed by the Federal Government or mandate that they be reduced to the extent that taxation would reduce the award if it were not to be taxed.

Mr. Chairman, we believe that in Section 1821, paragraph 4A, the terms "injury and personal injury, as defined to mean sickness or disease or bodily harm arising from provision of health care services" are perhaps so broad as to effectively make this bill one which would fund through a No-Fault concept any less than desirable result of a disease process whether it be caused by true malpractice or the naturally expected sequelae of the disease or treatment. If the National Legislature intends to compensate all individuals for sickness, disease or bodily harm arising from the pro-

vision of health care services, then the expense will be enormous. There should be an effort to amend this bill to accurately define malpractice and differentiate between malpractice as an act of poor performance as opposed to a theraputic misadventure and/or the natural sequelae of sickness and disease.

Mr. Chairman, in Section 1822, we recognize the initial stated intent to provide replacement service loss which is stated not to include non-economic loss. However, the wording in the bill which defines non-economic loss in paragraph 3, exludes pecuniary loss caused by pain and suffering. We believe that individuals should be compensated on a logical and reasonable basis and because "pain and suffering" is not measurable, we agree with the Supreme Court of Canada that if fiscal responsibility is to be maintained from a societal point of view, then awards for pain and suffering which are not measurable and purely emotionally determined should be excluded from recovery or else capped. We believe that the definition as included in the bill for non-economic detriment is unclear and should be reworked to allow the above concept to be implemented.

Mr. Chairman, in the bill as it is presently written, compensation benefits shall include reasonable expenses, including a reasonable attorney's fee. Nowhere in the bill is a reasonable attorney's fee defined. We are not opposed to a contingency fee as such, but we are aware that other providers of service for those insured by the Federal insurance system have specific rates of reimbursement fixed by the government and/or their intermediaries, and it would not seem unreasonable to accurately define in this bill what is to be considered a reasonable attorney's fee. Perhaps a reasonable attorney's fee is what would be considered reasonable by any prudent person. The National Legislature must keep in mind that the goal of compensating injured parties is that, and in doing so must examine where the dollars are presently going. If reasonableness is to prevail, then this matter should be addressed specifically. To do this would not be inconsistent with the way the Social Security Administration has dealt with other professionals.

We congratulate Mr. Gephardt and Mr. Moore for raising these serious questions to the level of national attention and allowing discussion at a Federal level to occur. We are ready to work with them and any other interested parties to discuss and implement these proposed reforms.

Thank you.

Chairman JACOBS. Thank you very much.

Dr. Todd.

STATEMENT OF JAMES S. TODD, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. TODD. Mr. Chairman, Mr. Moore, I am James Todd, a practicing surgeon in Ridgewood, NJ, and also a member of the Board of Trustees of the American Medical Association.

With me this morning are Betty Jane Anderson, our associate general counsel; and Harry Peterson, director of the AMA Division of Legislative Activities. We are pleased to be able to participate in this very meaningful hearing.

Professional liability problems have become more controversial and more serious perhaps than at any time since the seventies. We appreciate the actions of the sponsors of this bill in providing an opportunity for timely discussion of these issues.

The American Medical Association believes that professional liability costs, and the resultant effect on the practice of medicine, are among the most serious concerns facing the profession today. Like the sponsors of H.R. 5400, we are extremely concerned over the escalating tort liability cost and the impact and cost of the present reparations systems.

This bill, containing, as it does, certain innovative approaches and ideas, represents an important contribution to the ongoing tort reform debate. Recent trends in professional liability indicate an increase in the number of claims and the size and settlement of awards.

American medicine has experienced a dramatic improvement in medical technology. Complex modern armamentaria of scientific tests, procedures and treatments have been responsible for virtually miraculous medical advances. Naturally, each medical breakthrough has increased the expectations of the public with respect to what constitutes good health care.

Many of us now expect outcomes from every medical intervention regardless of the complexity of the treatment or the severity of the patient's condition. When the result is anything less than perfection, increasingly patients and people will seek legal remedies.

The increased number of claims together with the higher dollar awards has had the overall effect of contributing to the increase in health care costs. There are many reasons for this increase. Among these are increased physicians' costs due to premiums paid for insurance; other direct costs include resources required to underwrite physician-created insurance companies; hospital costs for inpatient risk management programs and liability premiums; and the cost of legal counsel employed by health care providers as well as the indirect costs attributable to defensive medicine.

It is important to discuss the issue of professional liability in legislation, to remember that the profession believes that injury that occurs as a result of negligence on the part of a practitioner, a patient is entitled to prompt and equitable compensation. Through professional liability actions patients that claim injury as a result of health care provided by a qualified professional can seem recompense for injuries. Indeed the existence of potential liability may well promote increased attention to the details of health care.

The central features of the bill permits a hospital or physician to offer to a patient that they believe has been injured compensation for that patient's net economic loss and by so doing foreclose the patient from suits for compensation in the court system. The American Medical Association recognizes the concerns and objectives of the sponsors with respect to helping resolve current professional liability problems and holding down health care costs.

The AMA also appreciates the efforts that have gone into drafting this bill and believes that it addresses important economic issues. However, after detailed review of the economic problems in the bill and the issues involved in the current professional liability environment, we cannot support H.R. 5400. In our view, the bill will not establish a more equitable compensation system. It is not clear that it will reduce instances of the practice of defensive medicine and rather than reduce aggregate health care costs, the bill could increase them and lead to higher liability premiums.

Provision for joint parties in the bill could lead to innocent parties with unpredictable consequences, and the bill establishes a Federal program in an area that traditionally dealt with at the state level for a problem not characterized by uniformity.

While we don't support the bill, we wish to commend Representatives Moore and Gephardt and their staffs for the time and thought that they have put into this important issue. We hope to continue this discussion with you in order to work for a solution that is agreeable to all involved. We know that it is our mutual objective that persons should receive prompt and equitable compensation for acts of malpractice.

Thank you very much.
[The prepared statement follows:]

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION, PRESENTED BY JAMES S. TODD, M.D., MEMBER OF THE BOARD OF TRUSTEES

Mr. Chairman and Members of the Committee: I am James S. Todd, M.D., a physician in the practice of general surgery in Ridgewood, New Jersey. I serve on the Board of Trustees of the American Medical Association. With me today are Betty Jane Anderson, AMA Associate General Counsel, and Harry Peterson, Director of AMA's Division of Legislative Activities.

The American Medical Association is pleased to offer its views on H.R. 5400, the Alternative Medical Liability Act.

INTRODUCTION

Mr. Chairman, I am sure that you and other members of Congress have been hearing from your physician constituents and others who are concerned about the increased costs of professional liability insurance and the increased incidence of claims brought against health care providers. This problem has become more controversial and serious than at any time since the professional liability crisis of the mid-1970s. This concern, especially when combined with the heightened concern over aggregate health care cost increases generally, has generated renewed Congressional interest in the area of medical professional liability.

Representative Moore indicated in his remarks upon introducing H.R. 5400 that he and Representative Gephardt introduced the bill for the purpose of promoting discussion on the issue of medical professional liability. Senator Durenberger, in a similar vein, indicated at the time he introduced S. 2690 (the Senate companion measure) that he does not agree with all the provisions in the bill but that the bill would provide an important focus for national discussion of the issue.

Mr. Chairman, we appreciate the actions of the bill sponsors in providing an opportunity for timely discussion of this critical issue. The American Medical Association believes that professional liability costs and the resultant effect on the practice of medicine are among the most serious concerns facing medicine. Like the sponsors of H.R. 5400, we are extremely concerned by escalating tort liability costs and the impact and cost of present laws to consumers. The AMA has been actively involved in developing and pursuing various approaches to this problem. H.R. 5400—containing as it does certain innovative approaches and ideas—represents an important contribution to the on-going tort reform debate.

The American Medical Association and in particular the state medical societies throughout the country have been very active over the years in working with legislators, lawyers, and insurors in developing solutions to problems in the tort liability area. In the mid-1970s, when the lack of availability of professional liability insurance had reached a crisis level, the AMA took a leadership role in encouraging physician groups to form medical liability companies. To assist these physician-owned companies, the AMA established AMACO, the American Medical Assurance Company, which specializes in reinsurance for physician-owned/medical society-created medical professional liability insurance companies. Incorporated in 1975, AMACO commenced business in June of 1976. AMACO now has outstanding reinsurance coverage of approximately $5 million for 17 physician-owned companies in 17 states representing 55,000 physicians insured. Also in the mid-1970s, the AMA developed model state legislation calling for a number of professional liability tort reforms.

Recent AMA activities

Mr. Chairman, last week at its annual meeting in Chicago, the AMA House of Delegates adopted a resolution encouraging all state medical societies to form coalitions supporting tort reform in each state representing numerous interests adversely affected by present escalating tort liability costs. The resolution specifically calls for these coalitions to address such issues as reform of laws governing product and professional liability, and development of appropriate public education programs regarding the impact and cost to consumers of present liability laws. We believe that these coalitions for tort reform will provide an excellent opportunity for public and private sector interest groups that share a common concern over liability costs to develop and pursue meritorious tort reforms. It should be noted that this coalition activity will not be limited merely to medical professional liability issues, but will involve product liability as well. In addition, AMA will be focusing greater staff re-

sources towards dealing with the evolving professional liability problems as it affects the practice of medicine in America.

A year ago the AMA appointed a special Committee on Professional Liability. This Committee developed a report concerning the direct and indirect costs of professional liability. The Committee continues to study trends in reported claims and premium rates and evaluates the impact of remedial tort reforms on claims and rates and will recommend promising avenues for solutions.

Mr. Chairman, the AMA and over 150 other organizations are currently engaged in the development of the Health Policy Agenda for the American People. Workgroup Five of this important project deals with the issue of professional liability. Although the project is not yet completed, the participating groups have adopted the following principles bearing on this subject: The primary responsibility of health care professionals should be the provision of high quality care by the most efficient means (Principle 5–5). There should be fair and adequate compensation for injuries that occur as a result of deviations from acceptable levels of professional and institutional care (Principle 5–5b). The Health Policy Agenda will soon develop policy recommendations in the area of professional liability, guided by these principles.

The malpractice problem

Recent trends in professional liability indicate an increase in the number of claims and adjudicated awards. The average incidence of professional liability claims has risen from 3.3 claims per 100 physicians prior to 1978 to 8.0 per 100 physicians in the period 1978–1983. According to AMA's Committee on Professional Liability, "no segment of litigation has had a more rapid growth during the past fifteen years than claims emanating from health care in the United States." There are many reasons for this increase. American medicine has experienced a dramatic improvement in medical technology. The complex modern armamentaria of scientific tests, procedures and treatments have been responsible for nearly miraculous medical advances. Quite naturally, each medical breakthrough has increased the expectations of the public with respect to what constitutes good health care. Many of us now expect perfect outcomes from every medical intervention, regardless of the complexity of the treatment or the severity of the patient's condition. When the result is anything less than perfection, increasingly people will seek legal remedies.

In addition, the amount of publicity given to large jury awards and public awareness of plaintiffs' rights and remedies has contributed to an increase in professional liability claims. For that matter, there is an increase in litigation generally in our nation. In the professional liability area this trend may be accentuated as we see more extensive education and training of lawyers in the handling of medical professional liability claims. Contributing to the increase in the amounts claimed are additional factors including general economic inflation and the escalating costs of legal defense.

The increased number of claims, together with higher dollar awards, has had the overall deleterious effect of contributing to the spiraling increase in health care costs. Direct costs include physicians' costs of premiums paid for professional liability insurance. There is a great deal of variance between professional liability insurance premiums which can be as low as $1,200 per year in Indiana to over $63,000 per year in New York, depending on locality, specialty and type of policy. Other direct costs include resources required to underwrite MD-created companies; hospital costs for patient liability premiums; costs of risk management programs by physicians and hospitals; the cost of legal counsel employed by health care providers; and indirect costs attributable to defensive medicine.

Fair compensation for injury

It is important in discussing the issue of professional liability and legislation dealing with this subject to remember that when an injury occurs as a result of the negligence of a practitioner, the patient should be adequately compensated for the injury. Through professional liability actions, patients who claim injury as a result of a deficiency in the health care provided by a qualified professional can seek restitution for their injuries. The existence of potential liability is also one means of encouraging services that meet an appropriate standard of care.

Mr. Chairman, unfortunately the tort system is not working. As evidence of this, only 20 cents of every premium dollar goes to an injured claimant. A higher percentage of premiums should go to compensate injured parties.

H.R. 5400

H.R. 5400 would establish an alternative system for settlement of medical professional liability claims for injuries arising from the provision of health care services paid for or provided by Medicare, Medicaid, the Federal Employees Health Benefits Program, the Department of Defense (or CHAMPUS), the Veterans Administration (or CHAMPVA), or "any other program established under Federal law."

The central feature of H.R. 5400 permits a physician or hospital to offer compensation to an injured patient for that patient's "net economic loss" and by so doing foreclose the patient from suits for compensation in the court system. The offer must be made within 180 days of the time of the patient's injury or discharge from the hospital. The making of a timely offer alone, unless found to be unreasonable, is sufficient to foreclose the tort remedy of the patient. Where an offer of compensation is not made, the traditional tort remedy would remain available to the individual. The bill provides that its alternative federal program would not apply to otherwise covered injuries if a state has in effect an alternative medical liability law which the Secretary of HHS determines substantially meets requirements established in the bill. The state law would be required to apply to all medical professional liability cases, not just those stemming from federally-financed or federally-provided care.

"Net economic loss" is defined in the bill as 1) reasonable expenses of medical care services, products, and accommodations, 2) loss of earnings, and 3) replacement services loss. Pain and suffering would not be a component of net compensable loss.

The American Medical Association recognizes the concerns and objectives of the sponsors with respect to helping resolve current professional liability problems and holding down health care costs. The AMA appreciates the efforts that have gone into drafting H.R. 5400 and believes that it addresses important health care issues. However, after detailed review of the complex provisions in H.R. 5400 and the issues involved in the current professional liability environment, we cannot support H.R. 5400.

Defensive medicine

As Congressman Moore indicated in his introductory remarks on H.R. 5400, the bill is intended to remove the impetus for the practice of defensive medicine by encouraging a change in the behavior and the attitude of health care providers with regard to their respc. sibility for liability.

Defensive medicine has been defined by the Secretary of HHS's Commission on Medical Malpractice as "the alteration of modes of medical practice, induced by the threat of liability, for the principal purposes of forestalling the possibility of lawsuits by patients as well as providing a good legal defense in the event such lawsuits are instituted." The Commission also noted that defensive medicine can be considered either positive or negative. Positive defensive medicine includes the ordering of additional tests or treatment primarily to prevent or defend against the threat of liability. Negative defensive medicine occurs when a physician does not perform a procedure or conduct a test because of fear of a claim even though the patient might benefit from the test or procedure.

It is unclear how the provisions of H.R. 5400 will decrease the practice of defensive medicine. Presumably defensive medicine is practiced by physicians who are sensitive to the increasingly strict standards of care that a court would impose in a tort action and, therefore, they will prescribe certain tests to provide added assurance of meeting practice standards.

If H.R. 5400 were enacted, would the practice of defensive medicine decrease? Any such decrease pre-supposes that physicians who can limit exposure to professional liability actions, such as proposed in H.R. 5400, will practice a different style of medicine based on the physician's ability to limit exposure to high judgments. Would such a system best serve the interest of American patients? We do not believe so and we do not believe that physicians will provide two levels of care.

Costs

It is very difficult, if not impossible to accurately estimate the cost impact of the bill due to the fact that the system is triggered by voluntary actions of a provider and the difficulty of predicting the provider's likelihood to opt for the new compensation system. The unpredictability is compounded by the ability of one provider to involve others in the compensation agreement, and by the fact that some patients are eligible for H.R. 5400's provisions and others are not.

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The bill's overall cost impact depends in large measure on the extent to which elimination of pain and suffering awards would be counter-balanced by increased claims.

Notwithstanding the difficulty of arriving at overall cost estimates for the bill, it is likely that the cost of professional liability insurance would be higher under the bill for a number of reasons, including the probability of offers on marginal claims not now pursued and the continued need for physicians to maintain both existing coverage and potentially increased coverage to cover the new program.

The bill could also create problems due to the role of the provider in deciding when to make an offer of compensation. Given the importance of this action under the system established under the bill, liability insurance carriers, not the provider, would most likely require control of all such compensation decisions.

Finally, litigation and legal expenses would not necessarily be lowered by the bill. There would be new reasons for involvement of the courts, such as discovery procedures with respect to patient injuries, and court review of any compensation offer over $5,000, review of "the reasonableness" of patients' claimed economic losses, and review of whether the provider is in fact accounting for the patient's "net economic loss".

Joinder of parties

The provisions in H.R. 5400 that would permit a health care provider, in tendering a settlement, to join any person who is also potentially liable for the personal injury and who may benefit from foreclosure of action raised serious questions about workability. Third parties so joined would be deemed to have agreed to pay a share of compensation benefits and reasonable costs of making the tender and paying benefits. Disagreements with regard to the third-party's share would be submitted to binding arbitration with shares based on comparative fault of the parties (other than the injured individual).

Federal vs. State solutions

Clearly whenever addressing federal legislation, the threshold question is whether or not the issue dealt with is appropriate for federal intervention. This question is even more pertinent when it comes to an area such as professional liability tort reform which has traditionally been dealt with at the state level. We believe that one of the most fundamental criteria for development of federal legislation is the existence of a problem throughout the country. In the case of professional liability, the evidence is clear that there are some states where there are serious problems of high insurance premiums and physicians leaving their specialties, yet, there are many other states that do not have similar problems. We remain hopeful that states will continue to be active in this area and develop programs responsive to their needs. We must caution Congress against adopting federal legislation applicable nationwide to deal with local crises.

CONCLUSION

Mr. Chairman, while we do not support H.R. 5400, we wish to commend Representative Moore and his staff for the time and thought that they have devoted to developing this proposal. We appreciate their consultation with us on this matter. The AMA will keep the sponsors of H.R. 5400 and this Committee informed of our activities on this issue. We will be pleased to continue to discuss this important issue with you in order to work for a solution that is agreeable to all involved. We know that it is our mutual objective that persons should receive adequate compensation for acts of malpractice. We believe that it is important that the bulk of the premium dollar go to the injured person as compensation and not be diverted to others.

At this time, Mr. Chairman, I would be happy to respond to any questions from the Committee.

Chairman JACOBS. Thank you, Doctor. I believe that completes the statements by the panel.

Mr. Moore.

Mr. MOORE. Thank you, Mr. Chairman.

This is an outstanding panel and I appreciate their comments. We certainly intend to study them carefully in ensuing months before contemplated action perhaps next year.

Dr. Todd, I understand that you are associated with the Physicians' Insurance Co. as well as being a practicing physician.

Dr. TODD. Yes.

Mr. MOORE. Do you believe there is an increasing pressure on physicians to be self-insured, not to carry insurance policies per se, and if that is the case, what is the impact on society if physicians in fact are not insured?

Dr. TODD. Well, you are quite right, Congressman, in that there is increasing pressure to self-insure for a variety of reasons. First of all, the commercial carriers did not appear to anticipate or respond to the problem in an appropriate fashion. Second, these are profit-motivated institutions in general, which are there to fine tune the insurance mechanism, to involve peer review in the determination of what is malpractice. After all through a physician the determination of malpractice is first and foremost a medical decision and only becomes a legal problem when the resolution cannot be reached.

We believe that by involving the physicians directly in their own operations by involving the peer review system we can fine tune the insurance mechanism, shorten the length of time between assertion of the claim and the settlement, and more accurately determine true damages.

Mr. MOORE. Is there a danger that physicians in this country who may not have access to a captive physician insurance company as you just described, is there a possibility that physicians will simply go uninsured?

Dr. TODD. There are certainly physicians who are doing that now for varying reasons. I do not believe based on the history of the past and looking at the rapid development of physician-owned companies throughout the country, that any physician would be forced to go bare because of the unavailability of insurance. The problem today is not availability, it is the cost of insurance.

Mr. MOORE. The point I am getting at, if costs get so high that a physician decides he will just take the risk, and a large judgment comes in, the physician cannot pay it, what happens then to the claimant?

Dr. TODD. We would hope that a physician regardless of the cost, as they work toward the solution of this problem recognizes a responsibility to society and after all no one in this work is perfect, there are legitimate mistakes and damages that occur and it is part of a professional responsibility of the physician to be prepared to compensate and help the patient that may be injured.

Mr. MOORE. I understand. What happens if he is not insured? We have companies every day that are facing the same kind of tort insurance problems, these go uninsured, if something happens—contractors notably—they let the suit go against the corporate shell, recover nothing and form a new corporation the next day in which case by lack of insurance the claimant in society is the one who has borne the loss, not the tort-feasor.

What I wonder is if we face that possibility in physicians?

Dr. TODD. I don't think we face it in the foreseeable future and if we did it would not be unique to congressional liability with the problem of the uninsured motorist and many other areas where it is a problem that has not been adequately addressed.

Mr. MOORE. In your experience in dealing with insurance, is the lack of a defined risk for underwriting purposes one of the major problems in professional malpractice?

Dr. TODD. It is very difficult and part of the problems with H.R. 5400 is the inability to clearly identify any event that can be agreed upon by provider and patient as a compensable event. When you have an automobile accident, that is a real event. It is something we know happened. When you have a work-related accident, it is a fairly straightforward event. But when you have the uncertainty of the response of a human organism to various treatments we see in the insurance industry suits filed for situations that the profession would generally agreed and in most cases the courts agree with us, are reasonable expectations of the severity of the illness and not the consequence of negligence.

We see a great problem in being able to define what is indeed a compensable event.

Mr. MOORE. In the tort system now this is wide open, of course. Under this bill we attempt to limit what we are talking about as a compensable risk or injury. We eliminate one of the things that I remember from my practice of law, sometimes being the largest item and the most difficult to predict, pain and suffering. Would removal of pain and suffering from the insurance point of view make the risk that your are insuring a more definable thing?

Dr. TODD. It would certainly increase the predictability of our potential liability on out. It would also have several other effects as well and that would be to allow the true damages to be better compensated than for the pain and suffering. The evidence has shown that in those States where pain and suffering has been controlled as a rational decision of society, if you will, that it has significantly reduced the rates.

The other problem with pain and suffering, particularly when it goes through the tort system into the courts, a blockbuster award on pain and suffering, then that increases the difficulty of settling those deserving cases at a reasonable level without involving the court system.

Mr. MOORE. Dr. Gibbs, a question for you, sir; you refer to the American College of Ob-Gyn studies of December 1983. From your study of that survey result what is your best estimate of the amount of defensive medicine now being practiced? What percentage in terms of defining it of the cost of what a physician orders now in your field attributable to defensive medicine and what percentage of physicians in your field are practicing defensive medicine?

Dr. GIBBS. Congressman, I have our assistant with us, head of our professional liability department but let me try to answer the question for you.

In his survey, approximately 80 percent of the responding obstetricians indicated that they were using more testing as a result of malpractice threats. Seventy percent of them reported that they were using more fetal monitoring. Somewhere around 60 percent said they were using more consultation. Fifty percent of them said they were using more referrals. All of those areas are adding considerable cost to the price of medicine and that is what makes up defensive medicine.

There are other areas that he looked at as well, but those are the major ones.

Mr. MOORE. What would you guess would be the increase in the cost of treating a patient by undergoing these additional defensive tests?

Dr. GIBBS. Mr. Raines informs me it would be somewhere between $3 to $5 per office visit.

Mr. MOORE. What percent increase is that? What is a normal office visit?

Dr. GIBBS. Probably 10 percent.

Mr. MOORE. Another question: In your opinion, how much of the cost of defensive medicine is really productive and what percent of it would be relatively unproductive?

Dr. GIBBS. I think that is just a very, very difficult question for me to answer and I don't think I can provide that—a good answer to that.

Mr. MOORE. Dr. Stewart, a question for you, if I may. First, do you believe a hostile environment exists between patients and physicians; and second, to what extent does the practice of defensive medicine and the litigious nature of our people affect the quality of health care being administered by the physician to the patient?

Dr. STEWART. I think it exists and I think it is sort of harmful because I think as you know that—if you practice medicine you are not practicing a science, it is not physics and arithmetic and two plus two is—and there is something which is not measurable which occurs in that relationship between a man and his wife, you cannot really measure that relationship. But there is something that is almost like a magic potion of understanding and trust between a doctor and a patient. If there is going to be some successful application of this art of medicine you have to have that.

I think anything that muddies the relationship that people have whether it be at home, between man and wife, or whether it be in doctor's office or hospital is a little bit unhealthy for the mental state of all the parties concerned. I think this adversarial process has certainly crept in and influenced people's attitudes and their expectations and their performance.

Mr. MOORE. Thank you.

Dr. STEWART. And then the costs related to it.

Mr. MOORE. I would just say in passing, Dr. Stewart, that we share the concerns you expressed in your testimony that this program may encourage payment to every single patient for every single illness or procedure. We don't believe that will happen because the provider controls when to offer a settlement. Logically speaking, in the case with no merit whatever, you would not make a settlement. The claimant's remedy would still be in the tort system. In that case they may have difficulty finding an attorney realizing you have this potential offer system, and one is not made.

Dr. STEWART. The reason for my comment was not to try to prevent people from being compensated but just to try to a—take the situation where someone comes to the hospital and they have had an accident or illness and in the process of the treatment and the illness they get sicker and then they end up with a lot of disability and no income.

Under the wordings of your bill I think sickness or harm or illness really is what you define as malpractice and I feel like it should be tightened up a little bit, otherwise the door is open for everybody to say my leg hurts now, because I fell and I should be compensated a little bit.

That could be very, very costly.

Mr. MOORE. I agree with you. We will look at that. That is not what we intended.

What we intend is that you have a malpractice claim within the meaning of the generally accepted term and we give you the opportunity to make an offer of settlement to avoid the tort system.

Thank you all for your testimony.

Chairman JACOBS. I address this question to the panel generally.

Beyond the factor of malpractice can anyone suggest any other inducement for excessive testing in any situation?

Dr. TODD. Well, Mr. Chairman, I think the whole issue of defensive medicine which is what you are talking about, needs to be addressed.

Chairman JACOBS. No, I mean not counting defensive medicine. Let me be more specific or lead the witness; what about cases where the doctor owns a laboratory or something like that? Can you say for certain that that is never a factor in excessive testing or would you in fact ascribe it all as I believe is logical to ascribe some of it, to the defensive practice of medicine?

I think the record ought to show your opinions with respect to that question.

Mr. BROWN. I think that personally there is probably—I would really not know the word to use, maybe an appreciable amount of excess testing as a result of some pressures of defensive medicine but I think we must also recognize that the health care industry is an industry, too, and it is an industry where money flows and where bottom lines are checked not only in the medical office but in the hospital where you find your large laboratories, and to say that the motivations that occur there to make additional tests are not present is really not looking at reality because those motivations to make an extra test because there are extra moneys to be made there certainly exists, and I think that has to be recognized.

This is an industry, too.

Chairman JACOBS. I wouldn't consider it reasonable to assume or even to assess the factors in terms of the size of the problem one way or the other, but I should think it would be impellingly logical to assume that at least that is a factor in some cases.

Dr. Stewart.

Dr. STEWART. Mr. Chairman, I am sure that there must be scallywags in medicine as there are in everything.

Chairman JACOBS. How about some subscallywags, bottom line wags?

Dr. STEWART. There are probably a bunch of bottom line scallywags who are bottom line wags, and I don't know how one would measure that.

But the biggest cause of medical liability suits is failure to diagnose and when I see as a neurosurgeon an individual who has banged his head and he has a headache and my clinical judgment says I think this child or this adult is OK, I have got to be very

reliant on my clinical judgment which is sometimes wrong and because of the threat of being caught I really don't have any hesitation to order a $350 or $400 test to be certain that my judgment is correct.

I could wait 3 or 4 days and watch and see what was going to happen, but society demands instant resolutions and if I don't instantly figure out what is wrong with the use of some of the technology we have I am placing myself at increased jeopardy.

So part of what I do is in a sense defensive and in part it is good medicine but it is not all good medicine.

Chairman JACOBS. I take it when we use the term "excessive" we mean precisely that. Dr. Todd, I would be happy for you to comment but I wanted to ask another question. But go ahead.

Dr. TODD. I was just going to say that human nature being what it is it would be naive to assume there are not physicians that are doing that but I think the issue of excess testing, quote unquote, goes a bit further than that and it has to be measured in human terms and public expectations.

Is the physician practicing a good style of medicine looking only at a portion of the patient? Or is it his responsibility to use those tests that are available in a screening technique perhaps to discover other disease?

It is clearly recognized that the discovery and treatment of asymptomatic disease and cheaper and more effective than waiting for the symptoms to occur. So many times what in a particular situation looks like an excessive testing situation may indeed be preventive medicine or screening of otherwise healthy individuals.

Chairman JACOBS. Doctor, the question I wanted to propound is, have you in New Jersey any legislation with respect to this issue?

Dr. TODD. No, we have not.

Chairman JACOBS. I mean malpractice, departure from the common law?

Dr. TODD. No, we have not for a variety of reasons. The main reason is when the profession got involved in the problem of professional liability its first two objectives were to one, fine tune the insurance mechanism to try and prevent the figures you have heard this morning of only 20 cents on the premium dollar ending up in the injured party's side; two, to look within the profession to see what we would do in terms of risk management to reduce malpractice or the appearance thereof which often gets us into the courts.

Our third goal has indeed now been to deal with legislation which based on several studies including the Rand Studies shows it will have the greatest impact on professional liability expenses and at the same time not deny the injured party due process or access to the courts, and that includes structured settlements to guarantee that a grievously injured patient will not receive a lump sum which they cannot control and eventually become wards of the State, but have ongoing compensation for their illness; collateral source legislation that says there should not be double payment for injury; and of course a consideration of the limitation on pain and suffering which in our estimation has no rational basis for determination and currently exceeds all reason.

Chairman JACOBS. Our new staff attorney, Karen Lloyd, has just briefed me on the statute in my State, Indiana: first it is a screen-

ing mechanism, a mandatory panel to determine the probable cause goes to work; then a cap of $100,000 per practitioner per incident with a $300,000 annual aggregate; additional recovery of up to $500,000 from a State fund, which builds a cap of $600,000 per incident and also a provision for voluntary entrance into arbitration.

How does that strike the panel?

Dr. TODD. Certainly——

Chairman JACOBS. Is there anything up-to-date in Indiana or what?

Dr. TODD. Indiana has been a benchmark for what a large percentage of the physicians would like to see but even in Indiana the costs continue to escalate. You have seen the compensation fund require additional contributions by physicians. There is no one single solution to the problem.

Certainly not a single legislative solution. It has to involve the profession, the legislature, the courts, and society in general.

Chairman JACOBS. Mr. Brown, I am not sure you suggested there may be a serious question with a cap. We have a cap in my State apparently.

Mr. BROWN. Well, for instance in some States caps would be unconstitutional.

Chairman JACOBS. No quid, you mean?

Mr. BROWN. That is right. Kentucky, my home State, a cap would be unconstitutional. Kentucky's Constitution is about 250 pages long, I think. It is a batch of statutes.

Chairman JACOBS. You once had two Supreme Courts at the same time you may recall.

Mr. BROWN. One of them does bar a cap on awards for civil damages. That provision does exist in other States. There would be a constitutional problem in some States with that.

The voluntary arbitration idea is something that we somewhat suggested in our written statement to this committee. The tender is an interesting idea but to literally deny the potential plaintiff the opportunity to have any say-so in whether or not his ultimate rights are to be denied is where we have the problem.

To give him some say-so may be through a voluntary arbitration scheme would be something that the association would really like to take a strong look at as a potential solution.

Chairman JACOBS. The committee is very much in debt of the panel. We are grateful. We know you have busy schedules and you are generous with your time.

I express the gratitude of the committee for it.

Our next panel will be the National Senior Citizens Law Center, Patricia Nemore; National Health Law Program, represented by Judith Waxman.

We can proceed in the order you are listed.

STATEMENT OF PATRICIA NEMORE, J.D., STAFF ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER, ACCOMPANIED BY TOBY EDELMAN, STAFF ATTORNEY

Ms. NEMORE. Fine.

Mr. Chairman, I am Patricia Nemore and I would like to introduce to my right, Toby Edelman, staff attorney with me at the

center. The law center is funded by the Legal Services Corporation and foundations to provide technical assistance and support primarily to legal services attorneys in areas of law affecting poor older people. The areas of specialization of the center's attorneys include medicare, medicaid and nursing home law.

Our own focus is on nursing home law. We are in virtually daily contact with legal services attorneys and members of the private bar who seek to enforce nursing home residents' rights. We appreciate the invitation extended to the law center by the chairman of the Subcommittee on Health to testify on H.R. 5400, the Alternative Medical Liability Act. We will be submitting additional and more comprehensive written testimony for the record.

We have had a very short time to review the bill and we have just some basic points we would like to highlight this morning. There are other issues that we see on a cursory reading of it, but we have not had the opportunity to develop yet. So we will appreciate submitting something more later.

The law center supports measures that enable older people more easily to receive adequate compensation for personal injuries caused by the malpractice of health care providers. H.R. 5400, however, does little to advance that goal, and in fact, has the opposite effect.

H.R. 5400 deprives people who receive Federal health benefits of access to the court on legitimate claims of medical malpractice. Health care providers have a clear incentive under the bill to offer potential malpractice claimants small amounts of money. The providers' offer of money, no matter how inadequate to compensate the claimant, precludes the claimant from filing suit.

The provider is the one who can opt into the system. The beneficiary has no choice. If the offer is made the beneficiary cannot choose to reject that system, and instead go into the regular tort liability medical malpractice system that currently exists.

Millions of people affected by these provisions under the Federal aspect of it, many of whom are elderly and living on fixed incomes are deprived of their day in court solely because of the source of their health insurance.

We believe that that raises very serious questions of equal protection. Moreover, H.R. 5400 severely restricts legal damages available to beneficiaries of Federal health benefits. The definition of compensation benefits set out in the bill is far too restrictive.

The absence of any compensation other than out of pocket expenses and lost income from work perpetuates an existing bias in the law of damages against retired people and unemployed people. Without the possibility of receiving general damages such as pain and suffering or punitive damages, poor people and older people are left with a clear message that they do not have intrinsic worth since they do not have earnings to be replaced by damages.

This very problem of proving the compensable value of the injury has been a major contributor to the dearth of malpractice actions against nursing homes despite years of chronicled abuses.

We would encourage development of a system that would reduce this bias rather than one that perpetuates it.

Our second major objection to the bill is that by encouraging out-of-court settlements and by precluding the award of general dam-

ages, the bill significantly undermines the private enforcement function of malpractice litigation. The threat of malpractice suits has frequently been cited, by those in government as well as out, as one element of quality control to restrain hospitals from unreasonable and health-threatening service cutbacks under medicare's new prospective payment system.

The private enforcement function of malpractice litigation may be even more important for nursing home residents than for hospital patients, despite the absence of large numbers of cases. There are more than twice as many nursing homes as hospitals, and many residents remain in nursing homes for several years. In the last few years, Federal enforcement budgets have been reduced to the point where, for a time, many nursing homes were not being inspected annually, despite a Federal statutory requirement of annual inspections.

Although private malpractice actions are not an ideal quality of care enforcement tool, because they come after the fact and after damage has already been done, they can, nevertheless, serve to set an example to deter similar behavior in the future. They also provide a public record of a facility's or provider's activity. Thus, the public nature of the action can achieve two quality assurance goals: Alerting other providers to the standard care to which they will be held accountable, and alerting the public to the particular problems of a particular provider. H.R. 5400 virtually eliminates these important functions of malpractice litigation.

We oppose H.R. 5400 and urge that it not be enacted.

As stated earlier, we have additional comments we would like to submit. We have not fully developed those issues and would like more time to look at them.

Mr. MOORE. The record will remain open for that purpose.

[The prepared statement follows:]

STATEMENT OF THE NATIONAL SENIOR CITIZENS LAW CENTER, PRESENTED BY PATRICIA NEMORE, STAFF ATTORNEY

We are Patricia Nemore and Toby Edelman, staff attorneys with the National Senior Citiens Law Center. The Law Center is funded by the Legal Services Corporation and foundations to provide technical assistance and support primarily to legal services attorneys in areas of law affecting poor older people. The areas of specialization of the Center's attorneys include Medicare, Medicaid and nursing home law. Our own focus is on nursing home law. We are in virtually daily contact with legal services attorneys and members of the private bar who seek to enforce nursing home resident's rights. We appreciate the invitation extended to the Law Center by the Chairman of the Subcommittee on Health to testify on H.R. 5400, the Alternative Medical Liabilty Act.

The Law Center supports measures that enable older people more easily to receive adequate compensation for personal injuries caused by the malpractice of health care providers. H.R. 5400, however, does little to advance that goal, and in fact, has the opposite effect.

H.R. 5400 deprives people receiving federal health benefits of access to court on legitimate claims of medical malpractice. Health care providers have a clear incentive under the bill to offer potential malpractice claimants small amounts of money. The providers' offer of money, no matter how inadequate to compensate the claimant, precludes the claimant from filing suit. The millions of people affected by the provisions of H.R. 5400, many of whem are elderly and living on fixed incomes, are deprived of their day in court solely because of the source of their health insurance.

Moreover, H.R. 5400 severely restricts the legal damages available to beneficiaries of federal health benefits. The definition of compensation benefits set out in the bill is far too restrictive. The absence of any compensation other than out-of-pocket expenses and lost income from work perpetuates an existing bias in the law of dam-

ages against retired people and unemployed people. Without the possibility of receiving general damages such as pain and suffering or punitive damages, poor people and old people are left with the clear message that they do not have intrinsic worth since they do not have earnings to be "replaced" by damages. This very problem of proving the compensable value of the injury has been a major contributor to dearth of tort actions against nursing homes, despite years of chronicled abuses.

Our second major objection to the bill is that by encouraging out-of-court settlements and by precluding the award of general damages, the bill significantly undermines the private enforcement function of malpractice litigation. The "threat of malpractice suits" has frequently been cited, by those in government as well as out, as one element of quality control to restrain hospitals from unreasonable and health-threatening service cutbacks under Medicare's new prospective payment system.

The private enforcement function of malpractice litigation may be even more important for nursing home residents than for hospital patients, despite the absence of large numbers of cases. There are more than twice as many nursing homes as hospitals, and many residents remain in nursing homes for several years. In the last few years, federal enforcement budgets have been reduced to the point where, for a time, many nursing homes were not being inspected annually, despite a federal statutory requirement of annual inspections. Although private malpractice tort actions are not an ideal quality of care enforcement tool, because they come after the fact and after damage has already been done, they can, nevertheless serve to set an example to deter similar behavior in the future. They also provide a public record of a facility's activity. Thus, the public nature of the action can achieve two "quality assurance" goals: alerting other providers to the standard of care to which they will be held accountable, and alerting the public to the particular problems of a particular provider. H.R. 5400 virtually eliminates these important functions of malpractice litigation.

We oppose H.R. 5400 and urge that it not be enacted.

Mr. MOORE. Ms. Waxman.

STATEMENT OF JUDITH WAXMAN, J.D., STAFF ATTORNEY, NATIONAL HEALTH LAW PROGRAM

Ms. WAXMAN. Thank you, Mr. Chairman. We appreciate Congressman Jacobs' invitation to testify today on a matter of importance to our clients; namely, H.R. 5400, the Alternative Medical Liability Act. I am Judith Waxman.

The National Health Law Program is a health law support center funded by the Legal Services Corporation to provide professional advice and assistance to legal services advocates and their clients. We have extensive and ongoing contact with poor people and their representatives throughout the country regarding a variety of health subjects, which are of vital concern to them. Our testimony is based on our experience in providing professional assistance to these clients.

The bill, H.R. 5400, sets up a Federal medical liability program which will go into effect in 1987, if States fail to set up their own alternative program. The Federal program would be applicable to claims provided under medicaid and medicare and other Federal programs. We object to this bill for a number of reasons. It is unfair to the poor, aged, and disabled because it eliminates compensation for noneconomic loss. Therefore these people will lose their ability to be compensated for injuries. The bill undermines quality of care by eliminating the deterrent to medical abuses. Many due process issues are raised. The bill is discriminatory against the poor and the elderly because it only restricts people on public programs from seeking appropriate redress. Lastly, we generally object to the analogy of tort liability in the automobile context to the medical context. We think that differences in the situa-

tions make no-fault medical malpractice very dangerous for our clients.

H.R. 5400 eliminates pain and suffering and other noneconomic loss from compensation. This elimination is particularly unfair to the low-income person. Many people on medicaid do not work for a variety of reasons. A young mother who is home with her children, a severely disabled person, or an elderly patient in a nursing home generally do not have wages. Retired people on medicare also are often unemployed. If these people do not incur medical and legal expenses beyond what they received from public programs, the limits on H.R. 5400 would make them unable to recover any damages for malpractices committed against them and they would be barred from seeking redress in court.

According to this bill, the low income person's injury is given no value. If that person is offered a token settlement amount, that person is then barred from getting his day in court on what the loss really means in his life.

Mr. O'Connell said this morning that maybe this approach is a little harsh and I heard someone else say maybe it is even unconstitutional.

I would take that one step further, which brings me to my second point, and say that eliminating noneconomic loss is even dangerous.

The bill exacerbates an already unbalanced system in which poor people and medically underserved people often get low quality care. The bill allows providers to lower their standard of care further for poor people because there is really no threat of any liability for actions concerning these persons.

In the current climate of cost containment, quality care could be further threatened. We have heard complaints from all parts of the country on the care people are currently receiving under medicaid case management systems and as a result of medicare and other State prospective rate setting systems. I mention medicare and medicaid particularly because the bill that would go into effect if States do not enact a law applies to medicaid and medicare recipients.

Case management systems which I referred to are capitated HMO type plans and sometimes screening programs that are being established around the country for medicaid patients. The systems are structured to include incentives for reducing utilization and thereby reducing costs. We think, in general, this is a good thing, a very positive step to reduce unnecessary services.

However, we have heard from people in Kentucky and Arizona recently, and there is the experience in California in the early 1970's, that show that these systems can and sometimes do result in reduced services to the detriment of the patient's health. The new systems simply do not have adequate quality controls.

We have seen evidence that people are not getting quality care.

Medicaid recipients need malpractice liability as a last resort deterrent to possible abuses.

Similar fears have been expressed about prospective payment systems. Health analysts who have written on the subject note that the threat of malpractice is a countervailing force to the potential problem of underutilization that our clients face.

Their reasoning is that the fear of malpractice will prevent providers from cutting back on the appropriate care despite economic incentives to do so.

Another concern we have with the bill is what we are calling our due process concerns. We cannot gloss over the importance of setting up mechanisms that will assure fair treatment for injured parties. H.R. 5400 leaves many unanswered questions as to how the process will work. Specific questions are, for instance, how will the individual initiate the process? Who will decide if the offered amount is sufficient? Who will decide the extent or severity of the injury, the extent of which affects the amount of compensation.

The bill gives no information on how major decisions will be made. I urge that protections are needed to get the patient's input into the process or else you will have a new system where providers get to have all the discretion. They will set the process in motion and they will be able to circumvent in all but a minimal way their liability for their actions.

One other objection we have to the bill is that we feel it is discriminatory because the program that goes into effect in 1987 will be restricted to participants in Federal programs who are in large part the poor and elderly. Beneficiaries of Federal programs will not be able to seek appropriate compensation for their injuries. Yet it will allow those people in private insurance programs, who have more resources, to seek higher compensation.

Studies show that the poor are the least satisfied with the care they receive and they are treated the most poorly. Yet the bill singles out these people and restricts their ability to redress wrongs against them.

In conclusion, I would like to say that we appreciate the efforts of those who want to address the problems of malpractice, but we must add that H.R. 5400 poses real dangers for the poor, disabled, and elderly and does have potential for great harm.

Thank you.

[The prepared statement follows:]

STATEMENT OF JUDITH WAXMAN, ON BEHALF OF THE NATIONAL HEALTH LAW PROGRAM

Mr. Chairman and members of the Committee: We appreciate Congressman Jacobs invitation to testify today on a matter of importance to our clients, namely H.R. 5400, the Alternative Medical Liability Act.

The National Health Law Program is a health law support center funded by the Legal Services Corporation to provide professional advice and assistance to legal services advocates and their clients. We have extensive and ongoing contact with poor people and their representatives throughout the country regarding a variety of health subjects, which are of vital concern to them. Our testimony is based on our experience in providing professional assistance to these clients.

This bill, H.R. 5400, sets up a federal medical liability program which will go into effect in 1987, if states fail to set up their own alternative program. The federal program would be applicable to claims provided under Medicaid and Medicare and other federal programs. We object to this bill for a number of reasons. It is unfair to the poor, aged and disabled because it eliminates compensation for noneconomic loss. Therefore these people will lose their ability to be compensated for injuries. The bill undermines quality of care by eliminating the deterrent to medical abuses. Many due process issues are raised. The bill is discriminatory against the poor and the elderly because it only restricts people on public programs from seeking appropriate redress. Lastly we generally object to the analogy of tort liability in the automobile context to the medical context. We think that differences in the situations make no-fault medical malpractice very dangerous for our clients.

H.R.. 5400 IS UNFAIR TO THE POOR, AGED AND DISABLED

H.R. 5400 eliminates pain and suffering and other noneconomic loss from compensation. This elimination is particularly unfair to the low income person. Many people on Medicaid do not work for a variety of reasons. A young mother who is home with her children, a severely disabled person or an elderly patient in a nursing home generally do not have wages. Retired people on Medicare also are often unemployed. If these people do not incur medical and legal expenses beyond what they received from public programs, the limits on H.R. 5400 would make them unable to recover any damages for malpractices committed against them and they would be barred from seeking redress in court.

Take the example of a young mother who is home with her children and becomes disabled as a result of a doctor's negligence. She may not be employed and have little employment capacity because she is untrained. Also, she has no one to care for her children if she works. Once she is disabled, her employment capacity, if any, will be further reduced and her children will be left with no one to adequately care for them. Yet under H.R. 5400, because her loss is not economic, she will be barred from compensation. Is her injury not worth compensation to her and her family? The result of H.R. 5400 is that the low income person's injury is given no value. If any small offer of compensation is tendered to an injured poor person, that person will be barred from getting his or her day in court.

Medical malpractice has traditionally been a matter of state control. Hospitals and doctors have long sought to abolish the right for patients to collect payments for pain and suffering. State legislators have recognized that such action would simply be unfair, not just to poor people, but to all patients. A doctor who is run over by an automobile can be compensated for pain and suffering. Yet, a person who is injured by a doctor, under this bill cannot be compensated likewise. If compensation for pain and suffering is a national problem it should be eliminated in all areas of the law. We should not simply let doctors be free from liability.

H.R. 5400 UNDERMINES THE QUALITY OF CARE

Malpractice liability does deter inappropriate behavior in health care providers. If the compensation is not effective or nonexistent as it is in this bill, then deterrence will be diminished and the quality of care lessened.

The dangers are grave for low income people. The bill exacerbates an already unbalanced system in which poor people are medically underserved and often get lower quality care. The bill allows providers to lower their standard of care further for poor people because there is no threat of any liability for actions concerning that person.

For example, our clients report that hospitals often provide inadequate emergency room care and then inappropriately transfer them to other facilities that traditionally serve poor people. Currently the only legal means of redress for the individual against the facility is a malpractice suit. If H.R. 5400 becomes law such individuals will have no redress.

Additionally the facilities under our current system know that the possiblility of litigation against them exists if they negligently endanger people's lives. If H.R. 5400 is law there will be no check against the hospitals' arbitrary decisions on the quality of their services.

In the current climate of cost containment, quality of care is especially vulnerable for the poor and elderly. Our clients have expressed concern to us about the kind of care they are receiving in case management systems and as a result of prospective rate setting.

Case management systems such as capitated HMO-type plans and extensive screening programs are being established in many states for Medicaid recipients. These systems are structured to include incentives for providers to reduce utilization of services and thereby reduce costs. We agree that reducing unnecessary services is very positive. However, experience has shown us in Kentucky and Arizona recently and in California in the early 70's that these systems can and do result in reduced services to the detriment of the patients' health. The new systems do not have adequate quality controls built in. We have seen much evidence of people getting inadequate care. Medicaid recipients are heavily dependent on malpractice liability as deterrent to abuses.

The Medicare DRG system and state prospective rate setting systems which are developing for Medicaid and all payers in some states also include incentives for reducing costs by reducing services. In fact under the DRG system hospitals are rewarded for providing less care. Again, reduced unnecessary services is a positive change but reduced services to the already medically underserved who do not re-

ceive adequate quality or quantity of care can be dangerous. Health analysts who have written on this subject have noted that the threat of malpractice is a countervailing force to the potential problem of underutilization. Their reasoning is that the fear of malpractice suits will prevent providers from cutting back on appropriate care despite the economic incentives to do so. If H.R. 5400 is law and malpractice suits are in effect abolished for Meidcaid and Medicare recipients, there will be no mechanism in place to balance the incentives to save money.

THE BILL RAISES SERIOUS DUE PROCESS CONCERNS

Processe to obtain redress which are simple and which people can easily understand and utilize must be included in this bill. We cannot gloss over the importance of setting up mechanisms that will assure fair treatment for injured parties. H.R. 5400 leaves many unanswered questions as to how the process for assuring fair compensation will work. Some specific questions we have are: how will an individual who is injured initiate the process; who decides what amount of compensation is sufficient; how can an individual object to the amount of compensation offered; and who decides that the injury was covered by the disputed actions and not by a preexisting condition.

For example, a hypothetical elderly woman on Medicare has been employed as a secretary and has had an injury inflicted on her throat so that she can no longer talk. Can the provider decide that she can still get a job as a typist and reduce his offer by an appropriate amount. If his offer to the woman is under $5000, there appears to be no way the woman can challenge the offer. The bill gives no enlightenment as to how many major decisions will be made. Without protections for the patients' input into this process, this bill will create a system whereby providers can easily circumvent liability for their actions.

H.R. 5400 IS DISCRIMINATORY

The bill creates a federal program to go into effect in 1987 that will restrict participants in federal programs, who are in large part the poor and elderly, from seeking appropriate compensation for their injuries. Yet, it will allow people in private programs who have more resources to seek higher compensation. The poor, disabled and the elderly often cannot protect themselves from potential harm. Studies show that the poor are least satisfied with the care they receive and that they are treated the most poorly. H.R. 5400 does not address this problem; rather it makes the situation worse by singling out public benefit program recipients for unfair restrictive treatment.

Also, there is some indication that the poor and elderly do not initiate many malpractice suits. It is generally wealthy people who have used this system. Singling out public benefit recipients will probably not even solve the problem the bill attempts to address.

NO FAULT MEDICAL MALPRACTICE IS NOT THE SAME AS AUTOMOBILE NO-FAULT

Some proponents of the bill argue that a no fault plan has worked in the automobile injury context and therefore is appropriate for medical malpractice cases as well. The two areas of liability are very different, however. In the automobile context all drivers generate risk and subject themselves to risk in approximately equal capacities. Drivers serve as a check on each other to some extent. In the medical context the provider runs no risk as compared to that of patient who subjects himself to the provider.

In the automobile context there is the factor of self preservation. Even the driver who generates the risk does not want to subject himself to injury or death. This self preservation instinct is not present in the medical situation. The provider is not inflicting injury on himself in the same way a careless driver is.

Lastly in the automobile context criminal laws are in place to enforce safety codes. No parallel exists in the medical context. License revocation which could be a check on negligent action is very rarely used.

Because the two areas of liability are so different, the success in the automobile area cannot be assumed to apply in the medical situation. A loss of the right to redress malpractice wrongs would be dangerous for many vulnerable populations.

CONCLUSION

We appreciate the efforts to address the problems with our current means of redressing medical injuries. However H.R. 5400 has a negative impact on the poor,

disabled and elderly. It poses real dangers for the medically underserved and has potential for great harm. We recommend that H.R. 5400 be defeated.

Chairman JACOBS. Mr. Moore.

Mr. MOORE. Thank you, Mr. Chairman.

I appreciate the testimony and certainly your points are well taken.

Ms. Nemore, what is the current situation in terms of the elderly filing suit now for malpractice? Do they sue as much or less than other age groups in society?

Ms. NEMORE. I don't have statistics on that, Mr. Moore. As I mentioned in my testimony a very difficult problem which attorneys who take tort actions recognize is the question how damages are assessed for a nonwage earning person. The difficulty of assigning a value to their harm is a great deterrent to suing and people who see a tort claim or malpractice claim as an appropriate remedy for damages that older people suffer find that to be a serious obstacle that needs to be remedied.

Mr. MOORE. According to the Rand Study which we have been looking at, they concluded that only one-fourth the number of people termed "elderly" filed suits as people who are under 65 years of age. They have concluded that this is because the elderly are fearful their physician won't treat them if they file suit.

They would rather absorb the potential malpractice problem than risk losing their physician.

Do you have any information on that?

Ms. NEMORE. I think that because my area of concern is nursing homes that I might be able to address that in that context.

There is a very serious fear of retaliation for nursing home residents to file a suit and, in fact, there is not a great body of tort law or malpractice law in the nursing home area. That is one of the reasons.

One theory put forth by attorneys who work in this area and who are trying to bridge some of the obstacles is that having a case in court can, in fact, be a deterrent to any threatened retaliation, that because you are before a judge and because there are other parties involved, that you can make clear that the provider had better take very good care of that particular claimant while the litigation is pending.

So that that would be a reason to permit people to be in court rather than to be working out out-of-court settlements.

Mr. MOORE. The Rand Study noted that perhaps the elderly had a greater potential number of claims for malpractice than any other group but for some reason, probably as you testified, they are not filing claims. That also concerns us, and caused us to wonder if it would be better to ensure compensation for what they actually lose than to preserve their right to file suit which they are not now exercising.

Ms. NEMORE. I think a system that allows people to waive certain rights in exchange for getting a different kind of opportunity is one we would certainly be willing to consider and possibly support.

One of my major concerns with this legislation is that the beneficiary doesn't have the option to say, I will go with the limited damages and forego the court system.

That is not their choice. That is the choice given the provider who may tender the offer or not. The person on the receiving end doesn't have that choice.

I think that is a serious problem.

Mr. MOORE. Another point you and Ms. Waxman raised as something that gave us a cause for concern and the reason the bill looks entirely different now than what it was when we started on it, was the notion of discrimination. The fact you have one group denied this right to go to court but the others in society who are not subject to a Federal paid health care plan of any sort do not have that same right or loss of right as the case may be.

That is why we drew this in a model bill form to encourage the States to perhaps adopt something like this for everyone. Would this solve your problem? If a State such as my own, Louisiana, passed this, so it handled all malpractice claims in this fashion, would that solve your problem of discrimination?

Ms. WAXMAN. Are you addressing me, Mr. Moore?

Mr. MOORE. Both of you, yes.

Ms. WAXMAN. The problem that would remain was the one we both raised in the first instance, that is even if the same rules apply to everyone, for our clients at any rate, the way the compensation is so limited, they would not really be entitled to any compensation for their injuries.

Mr. MOORE. That would be just a matter of fact, not as a matter of law. In other words, they don't have lost wages so they are not rewarded for loss of earnings. But clearly many elderly have other losses which will be recoverable under the alternative system.

Ms. WAXMAN. It is because this law eliminates any noneconomic loss.

Mr. MOORE. Right. That is the point. It is not the alternative law that prevents recovery for lost earnings, it is the fact that somebody who is retired and not working would not be losing earnings.

Ms. WAXMAN. I see the point you are getting at. That the rules apply to everyone. But, of course, it would negatively affect only the poor people, who would, in fact, not have any redress for malpractice injuries done to them because of the way the bill is structured.

Mr. MOORE. I think the point you are bringing out is an important social consideration. Someone who is retired would obviously not get anything for loss of earnings. However, I'm not certain it would affect a poor person who is unemployed in the same way. For someone who has never been employed, that may be a problem. For someone who is laid off and not employed at the time they are injured from malpractice, this should not be a problem. If the injury prevents them from working in the future, under this bill they could receive compensation for loss of future earnings. Ms. Waxman, your example of the woman at home with her children, is not answered by this bill. You have added that to our consideration and we thank you for it.

Ms. WAXMAN. The untrained person is another problem. Also the way the bill is, it appears the provider making the offer can decide the question of what the individual's employment was worth and what kind of replacement employment might be appropriate if the person can no longer pursue his or her chosen employment, and

what replacement of employment that person might have sought but chose not to. The bill leaves a lot of questions as to how all those issues will be determined. You may be creating more litigation in the end by this legislation than you are without it.

Mr. MOORE. We created the court review, to be sure that injured individuals are protected from a frivolous offer. We found when you narrow the question to "what is the economic loss," it is a more determinable measure of loss by reasonable minds than calculating punitive damages or pain and suffering.

Ms. WAXMAN. It is certainly more determinable. I would say it is really unfair, as I raised in the example, to the person who doesn't have that economic loss. Is their injury worth so little?

Mr. MOORE. That is a social decision we will be called upon to make. We made that decision in workmen compensation years ago.

One last point, Ms. Nemore. Is security a matter of concern to senior citizens ultimately?

Ms. NEMORE. Could you say that again?

Mr. MOORE. Is security a matter of concern, knowing that your economic loss will be taken care of as opposed to the unknown of recovery under the tort system?

Ms. NEMORE. Well, I think I would have to answer yes to that. I am not sure that this—this proposal provides that security.

Mr. MOORE. Thank you. I think your testimony has been helpful. We appreciate it.

Chairman JACOBS. I asked the same question to the previous panel, is either of you or any of you familiar with the Indiana statute and its operation?

Ms. WAXMAN. I am sorry, I cannot hear you.

Chairman JACOBS. The question is, is any of you familiar with the Indiana statute on malpractice and its operation, the screening, the cap and the arbitration?

Ms. WAXMAN. Very peripherally, no. I just know it exists.

Chairman JACOBS. Thank you very much for your contribution. We appreciate your appearance.

The next panel is the American Association of Retired Persons, Melvin Levitt, national legislative counsel; and—sorry. I have made an error, Mr. Levitt. I have skipped over a panel inadvertently.

I am told I shouldn't do that.

Mr. Joseph Metzger of Horty, Springer & Metzger, West Palm Beach, FL, and C. Thomas Bendorf, executive director and director of public affairs of the Association of Trial Lawyers of America.

We want you to proceed in your own fashion.

STATEMENT OF JOSEPH P. METZGER, ESQ., HORTY, SPRINGER & METZGER, WEST PALM BEACH, FL

Mr. METZGER. I am Joseph Metzger, a trial lawyer defending—primarily in my practice—hospitals and physicians.

I have been in the trial practice for approximately 23 years. This includes service on the bench as a circuit judge in Palm Beach County, FL. The theme of my presentation today relates to the emotional atmosphere wherein these medical malpractice cases are tried.

I have brought with me and I will place these in the record when I am finished, two articles, one from the Miami Herald, Palm Beach County, FL, Thursday, May 31, 1984, and the headline reads, "Judge Tosses $10.5 Million Malpractice Award."

The article to quote it refers to a Judge William Owen who is one of our most respected judges, and the article says this, "Judge Owen ruled Wednesday that the presentation of the case made it virtually impossible for the jury to consider the case dispassionately. No one would ever fault Mrs. Nightengale for becoming tearful during her testimony," he said, "yet that together with related testimony and the presence of Courtney"—and Courtney for the record was a brain damaged child—"and the presence of Courtney in the courtroom during crucial periods of the trial combined to compel such an emotional response as to make it impossible for the jury to avoid that emotional response."

Now, what I am saying is that in my experience as a trial lawyer and as a trial judge that the one most dangerous element in the medical malpractice trial is that of pain and suffering, if you will, the intangible; and the $10.5 million award so that you have a complete picture of it, the award was set aside, the court ordered a new trial but then in the alternative reduced that $10.5 million award to $2.3 million stating in his opinion that when he considered that the $10.5 million would be invested at 10 percent, a conservative rate, would yield $850,000 a year without touching the principal.

The end result of the case was of course that there will be a new trial and we will see what happens in that one.

The next article I brought with me was a survey conducted by the Miami Herald and again, Mr. Chairman, I will leave this here for the record, and this article was published in the Miami Herald May 6, 1984, and the title of the article is this, "Fear, The Doctor's Disease."

This article touches on some of the things that we have heard during the testimony today and it says this among other things, afraid of lawsuits, doctors are reaching medical decisions based less on their instincts and training and more on what they will be able to defend in court. They call it defensive medicine.

Then there are figures given from a survey saying that more than 80 percent of these physicians admit that they regularly do tests, they ordinarily would not have done absent this malpractice climate.

The theme of my testimony is that we have reached a point where the emotional element, the emotional response as referred to by Judge Owen, has become so important and so all-encompassing that in my opinion in many, many malpractice cases there is not a fair trial and I would hope that we can in a fair and reasonable manner consider this climate, consider this atmosphere and consider where we are going and consider whether our system can stand $10.5 million verdicts. Thank you.

[The newspaper articles follow:]

The Miami Herald Thursday, May 31, 1984

Judge tosses $10.5 million malpractice award

By BRIAN RICHARDSON
Herald Staff Writer

Calling a jury's $10.5 million malpractice award against two longtime West Palm Beach pediatricians "shockingly excessive," a Palm Beach County circuit judge Wednesday threw out the verdict and ordered a new trial.

Judge William C. Owen's order comes almost three months after a six-member jury found Drs. C. Jennings Derrick and Robert Eddleman negligent in their treatment of 15-month-old Courtney Nightingale in 1978.

Derrick had treated an estimated 50,000 patients before he retired after 40 years. Eddleman joined his practice some 20 years ago.

Courtney, now 7, suffered permanent brain damage and is confined to a wheelchair. Attorneys for her parents, George and Nell Nightingale, who now live in Fort Pierce, sued on her behalf. They alleged that Derrick failed to diagnose and treat severe dehydration and Eddleman did not administer enough medicine in time to stop the violent seizures that resulted.

After a four-week trial, jurors awarded $8.5 million to a guardianship to care for Courtney during her 71-year life expectancy. Her parents were awarded another $2 million.

Attorneys for the doctors filed motions for a new trial and to reduce the award. Wednesday, Owen granted both.

"The award of $8.5 million to Courtney Nightingale is one which the court views as being shockingly excessive on its face," Owen wrote in a seven-page ruling. "That amount, invested at 10 percent, a conservative figure on today's market, would yield $850,000 a year for as long as the money remained invested, without ever touching the principal."

Further, Owen ruled, if his order is reversed by an appellate court, the jury award should be reduced to a total of $2.35 million for Courtney and her parents.

The order will be appealed, Greg Barnhart, the Nightingales' attorney, promised.

"We think [the Fourth District Court of Appeal] will reverse it," Barnhart said. "There's no evidence to support his findings. [The reduced award] doesn't make mathematical sense, because the insurance company offered $4 million to settle [before the trial]. They know the case is worth more.

"If we're forced to re-try it," Barnhart vowed, "we'll get a bigger verdict."

Attorneys for Derrick and Eddleman could not be reached Wednesday evening.

Owen ruled Wednesday that the presentation of the case made it "virtually impossible" for the jury to consider the case dispassionately.

"No one ... would ever fault Mrs. Nightingale for becoming tearful during her testimony," Owen wrote.

"Yet that, together with ... related testimony ... and the presence of Courtney in the courtroom during crucial periods of the trial, combined to compel such an emotional response ... as to make it virtually impossible for the jury to set that emotional response aside ..."

While denying a motion to dismiss Eddleman from the suit, Owen praised the physician.

"Had I been the fact finder, I very well might have concluded that ... Dr. Eddleman's efforts ... far from being below the standard of care ... were in fact herculean and heroic," the judge wrote.

FEAR: The

That's why our rate of Caesareans is 50 percent higher than the national average.

The rumor raced through the doctors' lounges at hospitals: One of their colleagues had flat-out quit. Took his obstetrics practice and shoved it. Just couldn't take it anymore, fed up with hostile patients, constant threats of lawsuits, the whole money-making medical rat race. Gone to sell used cars.

It was delicious gossip, something the doctors loved repeating, watching the look of shock and awe and perhaps a little envy as yet another doctor heard the story; it was tantalizing, particularly so because not a small number of doctors in South Florida, in their 3 a.m. loneliness, fantasize about getting out. And here was a guy who actually had done it.

The rumor, as do many rumors, turned out to be essentially true. These days, you can find Dr. George Pickel, age 68 — graduate of prestigious Johns Hopkins medical school, obstetrician who delivered more than 5,000 babies in South Florida, a man widely respected by his peers — you can find George Pickel at a car-rental agency in Fort Lauderdale. He's a personnel director, not a car salesman.

"So the word has spread, eh?" he asks. "I haven't even been back to the hospital to clear out my locker. That's how clean my break was."

George Pickel, on his former profession: "It used to be that people got sick, and doctors took care of them. All of that seemed to change.... A lot of humanity has gone out of medicine."

Theirs is the noblest of callings, with the richest of rewards: the only profession that automatically confers both a formal title and a mantle of infallibility. Godlike, they heal the sick.

But, they cringe.

Dr. Daniel Seckinger, president of the Dade County Medical Association, calls it "a sense of free-floating anxiety." Other doctors use the word "paranoia." What they are describing is something of a nervous breakdown in the medical profession here.

A few have quit altogether: a pediatrician who became an attorney; a surgeon who finally succumbed to his obsessive fear of lawsuits (though he hadn't been sued since 1975); a gynecologist who vowed to drop out if he were ever sued, and kept his promise; a disillusioned internist who took a giant pay cut to go to work for the government.

Others have left the anxious cities for quiet countrysides, or have taken an early retirement.

Still others who remain have become suspicious and afraid of the very people they are supposed to trust. And with good reason. Patients are hauling them into court in record numbers: More than one in four Florida doctors will be sued this year.

Beset by enormous costs of malpractice insurance, many are hustling for business, cramming more patients into a day, reducing to the barest minimum the time any patient gets. The patients don't like it; the doctors don't like it. It is an erosion of what has been called the most intimate professional relationship in the world, in which every patient, often literally, stands naked.

Afraid of lawsuits, doctors are reaching medical decisions based less on their instincts and training and more on what they will be able to defend in court. They call it "defensive medicine." In response to a Tropic mail survey of 56 area obstetricians and gynecologists — the specialty hardest hit by malpractice suits — more than 80 percent admit that they regularly subject women to unnecessary tests and procedures so that they can say in a courtroom, if they have to, that they took all possible precautions.

This has driven medical prices up. But it also has more tangible, and more alarming, effects.

Consider Caesarean sections, incisions into the womb once performed only as a last-minute emergency procedure, when the life of the mother or baby was considered to be in jeopardy. Doctors often get sued now if they fail to perform them and a birth was imperfect, but they almost never get sued when they do one. A Tropic survey of hospitals in Dade and Broward counties shows that our rate of Caesarean sections is running almost 50 percent above the national average.

South Florida doctors, with one eye on the

JOHN DORSCHNER is a Tropic staff writer.

Doctor's Disease

By John Dorschner

courtroom, are reaching for the knife.

The threat of malpractice looms always. But it isn't the money that troubles them -- they've got more of that than most of us, and they can always raise their rates to pay for more insurance. The terror may come more from within -- from the psychos of perfectionists, not used to being wrong, not used to being chastised, not able to cope with failure, not ever.

"George *Pickel* dropped out?" asked a shocked Dr. Marlene Langer, a South Miami obstetrician. "George Pickel?"

Pickel was perhaps the last man most area doctors would have expected to leave: urbane, self-confident, an absolute professional.

Pickel even looks like a doctor: a firm jaw, a tinge of distinguished gray in his sideburns. He works now in an office that is bland and windowless; he has yet to hang anything on the walls, but he says he is content.

"I'd been unhappy for a couple of years. I'd made half-hearted attempts to shift around -- to become a corporate medical director, or to seek a business opportunity. But I don't have a business background. And then I was approached by Alamo [Rent A Car] and was offered a position at a very satisfactory salary."

Alamo, a nationwide car-rental company based in Fort Lauderdale, wanted him to be a personnel director, reporting directly to the corporate president. He calls his position "director of family wellness," dealing with benefits and morale for the "Alamo family," doing such things as organizing a stop-smoking seminar for employees. His salary is less than he earned as a doctor, but not much; he can still afford, he says, to pay the $25,000 annual tuition for his children's college education.

He made the move after being slapped with two malpractice suits concerning brain-damaged babies. His insurance company settled them out of court.

Dr. William Kirkley, his former partner: "He was not responsible, but he was absolutely devastated by the suits. He took it very personally."

Pickel: "An attorney told me, 'This is just business. Don't take it personally.' I took it personally."

The suits dragged on for years. "It was a blow to my ego. It created some self-doubts. And if you didn't have any self-doubts before, questions in a [deposition in a] malpractice suit would certainly raise them for you."

There was this thought, always at the back of his mind, that a lawsuit could strike at anytime. He could be bleary-eyed at 4 a.m. at the hospital, struggling to deliver a baby, and wondering if the turmoil of a lawsuit would re-appear, imagining that of the thousands of babies he had delivered, one could go after his life.

"I didn't like the specter of someone suing me at any possible moment, the chance of always being second-guessed.... I have colleagues who have eight or 10 suits against them at a time, and I don't know how they practice with that emotional load."

And he hated what medicine was turning into. "It's become a business -- the 'collection rate,' the malpractice insurance fees, total income -- much more than it used to be. I was falling into that trap like everyone else."

If he kept practicing this year, he says, he would have paid $30,000 for insurance. And he was concerned about ordering "defensive tests."

"We're talking CYA here, pal. Cover your ass.... If you didn't order it, and something goes wrong, and the defense attorney says, 'Hey what if you had ordered the X-ray, would you have noticed it?' And the answer is, yes, I would have noticed it. But that means that 99.99 percent of people are getting unnecessary tests."

Defensive medicine, he says, has led to "simply old-fashioned greed.... Doctors realize there's money to be made on tests, so they continue to order them."

At last he decided: "Medical costs have risen dramatically, patients were unhappy about the rising costs and became hostile, and the doctors were unhappy they weren't being paid. And it all feeds upon itself."

He talked it over with his wife and kids. They supported his move to Alamo. He doesn't know, or care, what other doctors might think of his move. He doesn't see them much anymore.

He had become a doctor because "I liked the

interpersonal relationships, I liked the income and I liked the prestige. My impression is that doctors now have the prestige of used car salesmen and President Nixon."

William Mirsen, a Coral Gables doctor who is about to become president of the American College of Obstetricians and Gynecologists: "The horrible feeling that we're going to be attached pervades us now. Lawyers say we're paranoid, but it's real."

Milton Marzetsky, a pediatrician who recently moved to Ocala: "There is no joy anywhere. You're completely hounded by malpractice in Miami."

Dr. Karl Kramer, a Kendall dermatologist: Two years ago, he awoke in the middle of the night, thinking about leaving Miami. He weighed his options, and decided to stay put: "You've touched a hidden feeling I've never seen anyone write about.... A lot of physicians are thinking about moving. A lot of the gratification is gone.... I'm 41, been in practice 10 years, and I don't know where I'd go..."

It's hard to feel sorry for doctors. They are the highest paid class of workers in America, averaging $105,000 a year. They can keep you waiting an hour, one year for three crisp minutes when you're feeling bad and perhaps scared, then charge you $100.

A Chicago psychiatrist who has been studying the morale of doctors: "The public sees doctors as all driving around in Mercedeses. Actually, they are a miserable group of people, regardless of what they drive."

Surveys have shown that their rate of suicide — even excluding those over 65 who may kill themselves because of declining health — is much higher than the general population's, maybe eight times as high. (Psychiatrists are most likely to commit suicide; pediatricians least likely.)

So what? If they can't find happiness in their Mercedes-Benzes, does it matter? It does, of course, especially when their mood affects their work. These are the people who control something that is more intensely important to us than riches or fame: our health.

Why have malpractice suits here and in other large cities snowballed? There are only guesses.

There is no evidence that doctors are getting more incompetent or more careless. Their training now is better than ever. The brightest doctors, the ones who get into the most demanding specialties, tend to congregate in large urban areas, such as ours. Yet general practitioners in small towns get sued far less than doctors in big cities, though they have less training. Perhaps, some experts suggest, patients feel more alienated from their physicians in urban areas, and lawyers may have something to do with it too. The greatest concentration of malpractice suits are filed in New York, California and Florida, the three states with the greatest concentrations of lawyers.

Obstetricians-gynecologists have been hardest hit of all the specialities. Two-thirds of them in the state have been sued. Their malpractice insurance has more than doubled in the past three years. In Dade and Broward, they now pay about $50,000 annually for $1.3 million of insurance. A quarter to a third of their bill for delivering a baby goes to pay their insurance.

Their mood is so frightened and bitter that, according to a state survey done by the Florida Medical Association, 25 percent no longer deliver babies and 30 percent are thinking of stopping.

In South Florida, the mood is even worse, because this is the area most afflicted by lawsuits, meaning Dade and Broward doctors must pay 45 percent more than others in the state for their insurance.

Area OBGYNs are at a breaking point, the Tropic mail survey suggests.

The survey was sent in March to the 69 active members of the Miami Obstetrical and Gynecological Society; 38 responded. The society, says President Horry Averetta, "has a good cross-section" of area OBGYNs.

Eighty percent said they would abandon obstetrics if their insurance premiums reach $80,000 annually, a rate predicted for a year or two from now. By limiting their practices to gynecology, their insurance premiums drop dramatically.

Already, their choices are affecting some areas. In Clewiston, on Lake Okeechobee, local doctors have stopped delivering babies and the area hospital has closed its maternity ward, largely because of the costly malpractice insurance. When pregnant women feel labor beginning, they must now drive 60 miles to the nearest maternity ward.

In Martin County, north of Palm Beach, despite bowling protests, three of the seven gynecologists have stopped delivering babies. They are men in their mid-40s, in the prime of their careers.

The riveting fear of all obstetricians is a brain-damaged infant. The appearance of such a baby in a courtroom has moved juries to gigantic judgments: One Jacksonville couple was awarded $9.35 million last year. Most insurance companies prefer to settle out of court.

The legal system, they say, has gone bananas, especially when attorneys can play on the emotions of jurors. The Florida Medical Association says that, between 1975 and 1980, when compulsory mediation panels examined the merits of malpractice suits, only three cases of allegedly brain-damaged infants were pressed. Since 1980, after the panels were ruled unconstitutional and malpractice cases could go directly to juries, lawyers have filed 63 cases of allegedly brain-damaged babies.

Parents, say the obstetricians, may be as responsible as attorneys. Dr. Frances L. Hovington, president of the state OBGYN society: "Back when families were having 10 or 12 children, if there was one cull in the group, it was the will of God. Now, every child has to be a president of the United States. It's a mindset. They want a good outcome because they're only going to have

George Pichel, former doctor now working for a car-rental agency: "It's become a business — the 'collection rate,' the malpractice insurance fees, total income — much more than it used to be. I was falling into that trap like everyone else."

one or two children."

Dr. Paul A. Gluck, a Kendall obstetrician: "It used to be that only a few babies were considered 'premium babies,' pregnancies you did everything you could imagine to protect, because of the age of the mother, or because she had had great trouble getting pregnant. Now, every pregnancy means a 'premium baby.'"

Most women these days ask for natural childbirth, and they're disappointed when it's the doctor's scalpel that delivers the baby.

Yet, nationwide, according to surveys of the National Center for Health Statistics, the rate of C-sections has risen from 4.5 percent in 1965 to 18.5 percent in 1982, the last year for which national figures are available. Much of the reason, say doctors, is that Caesareans have become much safer for the mothers, and new fetal monitoring equipment can now alert doctors when a baby is in distress and should be removed quickly from the womb.

But that doesn't account for the astounding rates in South Florida. A Tropic survey of every maternity award in Dade and Broward counties — with the exception of Homestead Air Force Base's, which is available only to armed service employees — shows that our rate of Caesarean sections is 27.2 percent. One hospital even had more Caesareans — 31

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percent — than natural births.

Altogether, Dade and Broward C-sections are running 47.6 percent above the national average.

It would be even higher, except for the rate at Jackson Memorial, a teaching hospital for the University of Miami med school. There, residents must consult with an obstetrics professor before a C-section. The professors make textbook decisions: Their insurance premiums are paid for by the institution, not themselves. At Jackson, the rate of Caesareans is well below most hospitals here — 21 percent.

If you exclude Jackson from the statistics, one in every three births in Dade — 32.9 percent — is a Caesarean section. In Broward, the rate is 25.4 percent.

Dr. Edward J. Quilligan, former head of the Society for Gynecological Investigation: "Ju-

ries seem to believe that, if it was a Caesarean section and the child was not perfect, it was an act of God. If it was a vaginal delivery and the child was not perfect, it was an act of the [illegible]."

Dr. Allan G. McLeod, a Miami OBGYN professor: "I don't think there's any questions the increased incidence of lawsuits has had an effect on the incidence of Caesarean sections."

There are people who studied while others partied, earning those astoundingly high grades needed to get into medical school. And then it gets worse. They are expected to memorize enormous chunks of material — parts of the body, diseases, cures, medicines. It is not an easy test kind of life, no introspective thoughts, no mining the depths of Heraclitus: name the bones in the foot, outline the treatment for Huntington's disease.

Says Stephen Greenwald, a Minneapolis psychiatrist: "If you aren't a perfectionist going in [to med school], you will be going out." The med student is indoctrinated with "the fear of the mistake." They have been trained all their lives to do well, and then it hits: the public accusation of "malpractice."

Case Western Reserve med school has been studying satisfactions and dissatisfactions of physicians for 20 years. Surgeons are the happiest, because they see direct results and are highly paid. Pediatricians are the least satisfied. They are constantly complaining of interfering mothers. But in general, the Case studies have shown, a doctor's greatest pleasure comes from making a correct diagnosis and ordering successful treatment.

Karl Kramer, Kendall dermatologist: "A lot of physicians are thinking about moving. A lot of the gratifications are gone. I'm 41, been in practice 10 years, and I don't know where I'd go."

His greatest displeasure — more than the average of 52 to 62 hours he works or the mounds of paperwork that confront him — is failed treatment. That is like getting an F in a class, and these are people who have never received an F in their lives. A doctor doesn't even use the word "death"; he talks only of "bad results." And he doesn't want to think about them.

Ian Nisonson, a Kendall urologist. "We like to feel like heroes, like young gods, but we're not. We do the best we can. We tend to think it's our fault, because we're victim of our own dreams — we think we can do the impossible, and we go around despondent when it doesn't work out."

Dr. Mixson, a widely respected gynecologist, estimates that he has had more than 100,000 patient contacts in his career. Two have led to lawsuits, and each has been "the most horrible feeling... the accusations, building a defense, torn up by opposing attorneys."

The Case Western study reported on one doctor whose "children were taunted on the way to school with cries that their father was a quack. Dinner invitations were mysteriously postponed... Patients canceled their appointments.... Being sued... was such a traumatic experience that he would have preferred being accused of any violent crime."

Dr. Sara Charles, a Chicago psychiatrist who recently published a paper on doctors who had been sued, reported finding that most suffered some kind of "inner tension," "depressed mood," anger, irritability and insomnia. Many felt such a sense of shame that they dared not tell even close colleagues about the lawsuit. It became a quiet, gnawing angst.

No wonder then that doctors will do anything to avoid a lawsuit and seem so compulsive in worrying about it. One plastic surgeon in South Dade, reports a colleague, is so concerned with the threat that he spends extra hours each week, dictating notes and impressions on each patient contact, material prepared for lawsuits that may never come.

"It used to be that in doctors' lounges at hospitals, and in cocktail parties before professional meetings, doctors talked about their golf games, or new surgical techniques," says gynecologist William Mixson. "Now, all they talk about are the lawsuits."

These fears — and the advice doctors are getting from their attorneys — has actually been damaging further their relationships with patients and, necessarily, the quality of their medical practices.

"I really avoid anything except the most professional relationship. You see how far my paranoia has gone," says one surgeon.

Dr. Mixson: "With the patient, we become defensive when we should be supportive." Take a hysterectomy, an operation that depresses and frightens many women. The doctor should be calming her, assuring her everything will be all right. But lawyers warn doctors to explain every possible complication, says Mixson, and that means the relationship with patients "is being eroded by the problem of litigation. That's wrong — dead wrong."

And the higher their insurance goes, the more they dash to see as many patients as possible. "So," says Dr. Allan McLeod of the Miami med school, "the doctor spends less time with each patient. Then the patients complain... and so you've created a vicious cycle."

Some doctors, says a physician at Broward General, are going so far as to avoid patients who they think may be litigious. "I know many physicians on this staff who are not taking certain patients, or are dumping certain patients, turning them over to other doctors, when they used to stick with them. They won't tell the consultant the truth — the doctor will say, 'I have to see my mother.'"

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Something even more insidious may be deteriorating medical quality — and that concerns a doctor's judgment. A good doctor orders tests, he takes a physical examination, he may consult with other physicians, but ultimately he makes a judgment. The best doctors make the best judgments. But with the threat of lawsuits always in the back of their minds, their judgments can change. Chester Cassel, a gastroenterologist: "Judgments don't count in a court of law. X-rays do." The more a doctor worries about how his decision will look in court, the more it alters his judgments. Anyone who practices what George Pickel calls "CYA" — whether he be doctor or government bureaucrat — is not doing the best job possible.

A Case Western study on malpractice threats concluded: "Medical care that patients need is often not being provided... because of the stress added to the risk."

An OBGYN who responded anonymously to the Tropic survey: "I have to practice following my conscience — not based on my malpractice risk. Unfortunately, the risk is so prominent in most obstetricians' minds they say, 'If I don't do a Cesarean and something happens...' thus accounting for many questionable and unnecessary procedures."

Doctors disagree adamantly on how the atmosphere became so bad. Many blame attorneys, but others say it's more than that. Dr. Chester Cassel: "It's a very hostile public. Patients are suspicious, they question the doctor, they don't put themselves in your hands. They're exploring you. And they want second opinions on everything."

A surgeon who retired at 58 rather than deal with malpractice problems: "Doctors failed to realize — it's their own problem, their own fault. Who are the juries? The juries are their patients. [But] they're blaming everybody but God."

Part of the alienation is technological. Dr. Daniel Sackinger, president of the Dade medical association, remembers that years ago, his physician father could do little about pneumonia except visit the patient at his bedside and try to comfort him as he went through the life-or-death agony of sweats and chills. Whatever the outcome, the doctor became close to the patient and his family.

Now, for pneumonia, a doctor can run some lab tests, order an X-ray, prescribe medicines and the patient may soon be back at work. But he may have seen the patient only for brief moments.

Today, there are many wondrous machines — CAT-scans, computers that measure every heartbeat in intensive-care units — that have advanced the science of medicine, but become a barrier between doctor and patient.

The patient often feels like a laboratory rat, and the doctor also experiences a "certain void," says Dr. Sackinger. "They feel now they're highly skilled technicians and paid to perform a circumscribed service, and they don't have the closeness to the patients they once had."

Ian Nisonson, a Kendall urologist: "Most doctors are very compulsive — not only doing good work, but getting a feeling of appreciation. When he [the doctor] is treated as just another person, another mechanic, it becomes a very paranoid atmosphere."

These grand machines and the perfectionist doctors led to the idea that medicine was a science that could not err. In the '60s, several medical journals published stories suggesting that technology would soon eliminate death itself.

It was something patients wanted to believe. In a book called *Medical Nemesis*, Ivan Illich, the philosopher-priest, traced the perfectionism in medicine to the decline of religion in Western civilization. Doctors became the new gods, death was denied. And if there was a "bad result," the doctor must somehow have screwed up.

Today, doctors and their supporters are in full-fledged retreat from this grandiose image. Attorney Rex Conrad, who represents many doctors: "Now, [court] judgments are often based on having failed to effect a cure. Medicine perhaps sold itself too well in the '50s and '60s — about rendering cures, but it's

Continued on page 24

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still an art."

Urologist Nisonson: "Just be religious a little bit. Think of the complexities of living, think of the Bible, the New Testament and the Old Testament — our life is a spark and then it's gone. Somehow we lost the ability to appreciate who we are.... I think there are mysteries and powers far beyond our measure to comprehend."

Humans, in other words, are mortal.

So are doctors. And they, like other mortals, are not perfect. But Jack Christie, a widely respected South Miami surgeon, is one of the few to confess it: "For example, on colon operations, out of 100, textbooks say, six will leak. Three will die. And it may be that one of those six — that is, one of those original 100 — was due to my mistake. Maybe I shouldn't say that, my colleagues always tell me I shouldn't say it, but it's OK if you print it right.... What I mean is that if I had it to do over, I'd do it a little differently."

Much of the patient hostility, however, say doctors, is traced primarily to the cost. Medical prices have been increasing far faster than inflation averages, perhaps because insurance companies and governments were paying so much of the cost.

"Patients," says Dr. Chester Cassel, "didn't care what they paid. And the doctor was coerced or prostituted into the higher fees."

Recently, to cut back on the soaring costs, the federal government, large private employers and insurance companies have been fighting back. The government is now initiating Diagnostic Related Groups, a move that doctors fear will revolutionize hospital care. DRGs state, for example, that an appendectomy should require two days in the hospital and so many tests, and that's all the government will pay for through Medicare. The latitude of doctors is going to be greatly restricted.

Private companies are also leading the way with Preferred Provider Organizations. The big insurers are now going to hospitals and doctors, demanding major discounts in costs. In return, the insurers will send all their customers there.

Most doctors hate the concept, because it means outsiders are telling them how to handle their patients, and forces them to band into PPO groups, something that the highly individualistic physicians despise.

"I don't want to be a K-Mart doctor," says Dr. Nisonson.

Yet Nisonson, despite his complaints, has joined a PPO-style group called the Association of Southwest Dade Physicians, led by surgeon Jack Christie. Christie's group, which has more than 400 physicians, is hoping to persuade insurers to forget discounts and instead look at less regimented ways of cutting costs, with the results reviewed by outside professionals.

Even so, these moves by insurers and Medicare are altering changes in the doctor-patient relationship almost as great as the threat of malpractice suits. Dr. Seckinger of the DCMA calls these developments "a tidal wave that is wiping out all the traditional values and leaves the physician anxious and bewildered."

The "tidal wave," however, may run into problems with doctors' lawyers, who are telling them to ignore the government's cost-cutting guidelines. Bruce Schwartz, who represents many Hollywood doctors: "If there are tests that could have been run and they weren't and something goes wrong, they're held responsible.... If a pregnant woman has a back pain, it could be a ureteral problem, and you better refer them. If there's any possible referral, damn the expense, because if you don't say that, it's a cause of negligence."

Some physicians are taking the easy way out and retiring well before they wanted to. It used to be that doctors, as they approached their late 60s, would simply scale down their practices, keeping a few old patients, not taking on any new ones. But insurance companies require the same enormous malpractice premiums whether a doctor treats one patient a week or 100.

"The doctors are fading away, but don't tell anybody," says one, latter Broward cardiologist who is giving up direct medical practice at the age of 65. "It's ego — I can't say I will have the energy to fight all these lawyers. I think that type of very subtle thing is going on. You don't know how many are doing this."

Others are simply moving away. It used to be, say long-time doctors here, that virtually no physician ever left Dade County — the area was booming and it was considered a grand place to live. But in 1982, a survey on malpractice problems by the DCMA revealed that at least 20 percent were seriously considering moving.

No organization keeps track of exactly how many doctors have left, but a few phone calls to local physicians uncovers two dozen who have moved from Dade and Broward recently: a pediatrician to Okeechobee, an internist to Clearwater, another internist to Estes Park (Colorado), a plastic surgeon to Ketchum (Idaho). Two doctors have moved, independently of each other, to Bismark, N.D. And at least a half-dozen have settled in the Ocala area.

Talk to them, and the reasons they give for moving are much the same as other persons: fear of crime, tired of hearing Spanish, that kind of thing. They talk about their new locations with enthusiasm: living in the country a short drive from their office, less traffic, good fishing.

Many do not automatically mention malpractice threats as a reason for their move. In fact, they don't volunteer information about medicine at all, unlike their colleagues here, who almost compulsively discuss lawsuits and PPOs and DRGs. But ask those who have moved about the attitude of patients to their new surroundings, and the talk changes.

Listen to a Hispanic doctor who moved to a small North Florida town after 20 years in Miami: "Patients are much easier to treat and to handle here.... It's really not fun in Miami anymore. I've never been sued, never had any problem, but there is more and more pressure

Dr. Daniel Sechinger, head of the Dade medical association: "A tidal wave...is wiping out all the traditional values and leaves the physician anxious and bewildered."

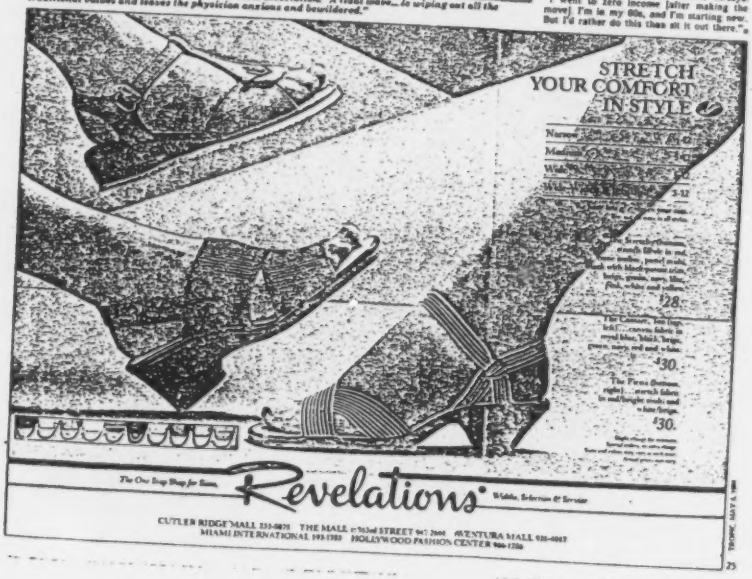
from different entities. It's a full-time business there, with very little regard for the practice of medicine... The public lost respect for doctors. Maybe it was our fault."

But this may not be the whole story. Several doctors in Dade confess that they are in a medical rat race, seeing 40 or so patients a day, unable to chat with any of them for very long. In a new location, in a small town, where the doctor is seen at the pharmacy magazine rack or the public golf course, he becomes a person to them, but he is also changing, slowing his pace, usually seeing fewer patients, spending more time with them.

Milton Mazursky, a pediatrician who just moved to Ocala after 30 years of practice in Miami Springs: "Here people seem to appreciate you more. They seem more relaxed.

"In Miami, after a busy day in the office, I'd have to drive all over the city to hospitals, making rounds. Because traffic was so bad at 5, I'd wait until 7 or 8 p.m. And then I'd come home at 10 or 11 every night." In Ocala, he lives in the country, a 10-minute drive from his office, and he has to see patients at only one hospital, which is close to his office.

"That gives me a lot of free time," he says. "I went to zero income [after making the move]. I'm in my 60s, and I'm starting new. But I'd rather do this than sit it out there." ■



Chairman JACOBS. Thank you, sir.

STATEMENT OF C. THOMAS BENDORF, EXECUTIVE DIRECTOR AND DIRECTOR OF PUBLIC AFFAIRS, ASSOCIATION OF TRIAL LAWYERS OF AMERICA

Mr. BENDORF. Mr. Chairman, I am Tom Bendorf, an attorney from Columbia, SC, I represent the Association of Trial Lawyers of America. I believe that I may be distinguished here because I am going to present you with facts and I will do that now.

If I may, this document that I am going to present to you constitutes the totality of the information on the medical malpractice insurance business since 1955.

Since 1955 the insurance industry has received more in investment income on loss reserves for medical malpractice than it has paid in claims. Many companies, St. Paul, for example, have actually transferred to surplus from those reserves more money since 1955 than they have paid in claims.

Information is available really only since 1975 when for the first time the insurance companies started reporting but I thought you might be interested in earned premiums for the selected companies reported by A.M. Best, in "Casualty Loss Reserve Development."

Since 1977 and in view of the charges of the horrendous increases, and in view of many other statistical charges made without a statistical basis, they are interesting, in 1977, $1.131 billion; 1978, $1,162 billion; 1979, $1.165 billion; 1980, $1.193 billion; 1981, $1.229 billion; and 1982, $1.294 billion.

All of this information is assembled from the annual reports of the insurance companies filed under oath with the State insurance commissioners. This information is part of the tax return filed with the IRS. So I think it is good information. I think it is accurate information. In about 2 months we will be able to update it for 1983 because these books come out in late summer.

There have been so many high fastballs tossed across the letters today it would take me about 5 hours to belt them all out of the park. The underlying characteristic, however, in this and all other so-called reform proposals is to abolish general damages. A few of us went to Russia last summer as lawyers and we spent our time with lawyers, and they shared the concept that general damages are totally inappropriate in that kind of society.

They have no moral damages. We still have. We are almost unique on this planet.

I have a vision of Yasha in an Eastern European country wandering down a cold gray street and up to a cold gray building walking in the door where a little gray woman sits behind a gray desk and saying to her, "My name is Jascha. I have lost three fingers."

She looks in the book as some of the panelists today would advocate and she says, "forty-two rubles." And he says, "But my name is Jascha Heifetz." She says, "It says nothing here about Heifetz. Forty-two rubles, three fingers."

That isn't our way of life.

It isn't the way of life for doctors when they become plaintiffs. They recognize that there are values to life other than net economic loss. To suggest that injured victims should become mere brokers

recovering from an insurance company in order to pay the doctor, repair the damage that the doctor did, suggests little respect for human values.

I appreciate the opportunity to be here at the opening of Pandora's Box. I did learn one thing that is important. I think I went on the retired list the other day and I had become, I thought, a beneficiary of CHAMPUS. Now I suspect I will be a victim of CHAMPUS so I will retain my commercial insurance. I will retain my right to recover, to be made whole against anybody who tortiously injures me. In that respect I guess you will in fact save the Federal Government money because the enlightened purchaser of insurance will in all probability not avail himself of that system which will wipe out his right to be made whole. He will continue to rely on commercial insurance for health.

I will be delighted obviously to answer questions but I will also be delighted to update the material that I have provided you with when these figures arrive for 1983.

Thank you.

[The prepared statement follows:]

STATEMENT OF C. THOMAS BENDORF, EXECUTIVE DIRECTOR AND DIRECTOR OF PUBLIC AFFAIRS, ASSOCIATION OF TRIAL LAWYERS OF AMERICA

We are delighted to respond to an invitation which is based upon an intention to promote discussion on the issue of medical malpractice.

My name is Tom Bendorf, I am an attorney from Columbia, S.C., and I am here representing The Association of Trial Lawyers of America.

We would expect that this will be the first in a number of hearings held by this committee on the subject of malpractice as it may relate to Federal Health Programs.

We have noticed with interest that this proposed legislation has been referred jointly to four other committees and we look forward to the opportunity to testify before those committees as well over the years.

This committee will have an opportunity over the next several years to determine the true facts. You have excellent staff and your committee is not known for the blind acceptance of the incredible hyperbole which has preceded most discussions on the subject. You need not rely on innuendo and the rantings of those who would emulate the Communist nations in the their disbelief of and disregard for what they refer to as "Moral Damages." (Which we call "General Damages" which others call "Non Economic Detriment".)

The most creditable aspect of the history of our nation is our recognition of and zealous protection of individual rights, human rights, and civil rights. Our state courts, in the recent past, have been called upon to strike down a myriad of efforts to limit the rights of our citizens to be free in their persons from the tortious misconduct of others, or if injured to be made whole by those responsible.

Proposals such as we see here today which would make a mere broker of an injured victim, make of a victim the simple means of merely subsidizing others for the costs of the wrong will in the long run so offend the conscience of a nation of free men as to be refuted wherever it appears and this is justly so.

The proposition that the cost of reparing the damage to the innocent victims of the misconduct should be considered as substantially contributing to the high cost of the delivery of health care in this nation is astounding. If the figures cited as the cost of the system are accurate (three hundred twenty billion dollars) then the costs of repairing the victims (one billion dollars) does not seem too much. One-third of one percent for the system of justice we all hold so dear, the same one third of one percent to produce such changes as sponge counts (defensive medicine) and all the other reforms in the practice which have led to greater security for patients; potential victims all.

This effort is obviously only one more in the long battle to eliminate general damages.

They are as likely to be as unsuccessful as most such efforts. We hope that the committee can get back to the containment of the other 99.66 percent of the exploding health costs.

We would like to see an end to malpractice suits when the end is the result of the elimination of malpractice. But we obviously will oppose any effort to end malpractice suits by simply eliminating the rights of the victims, by eliminating justice.

We appreciate the opportunity to contribute to these deliberations. We shall be prepared to support these efforts in the search for truth.

Everyone knows that insurance simply is a risk pooling mechanism. That is any number of individuals who suffer some risk of loss can, by pooling their risk, reduce the potential impact on any one of them and bring the total loss into a manageable amount. That was true when merchant fleets began pooling their losses over two thousand years ago, it is true today when professionals, be they doctors, lawyers, architects, or whomever, pool their risk under some sort of insurance mechanism.

Now, what happens when the insurance company receives a dollar in premuim from the individual who wishes to shift his risk to the insurance mechanism? The insurance company receives the dollar, they apply a certain amount of it to their expenses, acquisition expenses, operating expenses, etc., and they apply a certain amount of it to what is known as "incurred loss." "Incurred loss" is a figure that really comes into play at the end of the year when they file their annual report. At the end of their year when they file their tax return they will have determined what their incurred losses will be for the year's premiums. Incurred losses consist of losses paid, change in reserves for known claims and change in reserves for claims incurred but not reported (IBNRs). They also deduct loss adjustment expenses and reserve for loss adjustment expenses. When they add their expense package and their incurred losses and incurred loss adjustment expenses and compare those to premium dollars, they have an underwriting profit or an underwriting loss. The losses paid portion of incurred losses represents those dollars paid to claimants during that calendar year for occurrences of all prior years and for occurrences of the current year. The reserves for incurred losses and incurred loss adjustment expense will be used to pay in future years any claims tht arise as a result of occurrences this year. Now these facts remain the same whether we are talking about occurrence policies or claims made policies.

Medical malpractice, legal malpractice, architects malpractice, or errors and omissions insurance or professional responsibility insurance have what has become known as a long tail. They spell it t-a-i-l, we spell it t-a-l-e. This can be a long tail, because the statute of limitations ordinarily runs from the time the person is injured, or knows that he is injured or should have known that he is injured. In the case of medical malpractice or legal malpractice a substantial amount of time can pass after the occurrence itself. For example, a child is brain damaged at birth through the negligence of an anestheologist or the negligence of an obstetrician. That child's statute of limitation may be tolled, it generally does not begin to run until the child is twenty-one. Many states have reduced that age, but the same theory that does not allow a minor to contract should not allow a minor to give up his rights until he has reached his majority. And this long tail, the high reserving that is required to overcome inflationary forces, produces curiously and concomitantly a tremendous amount of investment income for the insurance company. The insurer is required by the regulator, the state insurance commissioner, to maintain a certain level of loss reserves. And because he has these reserves for decades, literally, he may make a fantastic amount of investment income by investing those assets which are in effect frozen by the requirement of the commissioner that the insurer maintain a certain level of reserves. The insurance companies like to say that reserves are liabilities and that liabilities do not earn income. That is true. There is an asset, however, which is out at investment, which asset is encumbered by the liability. And thus, the insurance company is making incredible profit while they are holding those assets for ultimate payment to claimants. This is not necessarily true in other kinds of insurance. Workmen's compensation insurance does not have a long tail. Auto liability insurance does not have a long tail. Home owners has virtually no tail at all.

Product liability does not have a long tail, but all types of professional liability may remain a risk for literally generations. Let us take a look at the universe, as best as we can understand it, of medical malpractice insurance.

Medical malpractice has been reported as a separate line since 1975. In eight years from 1975 through 1982, the leading insurers took in $10.62 billion in earned premiums. During that same period they paid claims of $2.05 billion. They currently have reserves in excess of $7.978 billion, and their investment income, an estimate based on a 10% rate of return for 1975–1982, is approximately $2.755 billion. In other words, they have made more in investment income on medical malpractice reserves than they have paid out in claims. The average claims paid per doctor in the United

States seems to be somewhere in the neighborhood of $2,300 a year. And the base of this kind of information; what is the justification for $5,000, $10,000, $20,000, $35,000, a year premiums being charged certain physicians and surgeons in this country today? The real answer, of course, is that there is no justification.

In truth, the doctors have, over a large part of this country, learned this and have undertaken to pool their own risk without going to the commercial carriers. These are known in the trade by a euphemism, they are called "bedpan mutuals." Doctors, hospitals, health care providers, have undertaken to insure themselves and have met with great success throughout the country. Currently the harbingers of doom and gloom and the commercial insurance industry have pointed to impending disaster for these so-called "capitives", for the bedpan mutuals. And to an extent, because the bedpan mutuals are regulated by the same insurance commissioners, and because they have to maintain the same level of reserves in spite of the fact that investment income would seem to produce dollars at a greater rate than claims produce negative dollars, the history shows that the bedpans are alive and well and probably represent the wave of the future in professional liability insurance.

Perhaps the harbingers of doom for the doctors mutuals would explain, or can explain, why St. Paul by December 31, 1982 had reduced its estimate of incurreds for 1975 by $10.720 million and for 1976 by $39.015 million, effectively transferring, therefore, from their estimate of incurred losses and their loss reserves, to surplus, $49.735 million for those two years alone. Or, perhaps they can explain why Aetna by 1982 had reduced its estimate of incurreds for 1975 by $2.726 million and for 1976 by $980 thousand, effectively transferring, therefore, from their estimate of incurred losses and their loss reserves, to surplus, $3.706 million for those two years alone. These are hardly manifestitations of squirrels gathering nuts in preparation for a hard winter.

What lies behind all the rhetoric about medical malpractice insurance, however, is nothing more, nothing less, than medical malpractice itself, people being unnecessarily, unjustifiably, unconscionably injured and killed by the providers of medical service and care.

Everyone knows about instrument counts. Despite the perfect sense that they make, it was only after numerous successful lawsuits that they were adopted as standard operating procedure across the country. And, yet, incredible in themselves and even more so in their proximity in time, two instances of medical neglect show what the real "medical malpractice crisis" is all about.

In March of 1981, the Washington Post reported that Mrs. Elaine Mezich, of Seattle, developed a sharp, cutting pain in her abdomen and was rushed to the hospital where x-rays indicated a 6-inch pair of foreceps, left there, as it turns out, five years previously during an operation. Less than a month later, the Post ran an article about a 31-year old nurses' aide who hurt her back and went in for precautionary x-rays. Her physicians told her that there was nothing wrong with her back, but that there was something else she should know. In her abdomen was—guess what!—a 6-inch pair of forceps, left there, it turns out, 5½ years previously during an operation. (These were not the same woman.)

Even more frightening was an AP report, published by the Post between the "forceps" articles, about Virginia Edmonson and Annie Robinson, who checked into a Philadelphia hospital in March. Mrs. Edmonson, who checked in with a ruptured disc, had a nodule removed from the parathyroid gland in the front of her neck, while Mrs. Robinson, who thought she was going to have her parathyroid gland removed, underwent the initial stages of a cervical laminectomy at the back of her head. The hospital admitted the error and said it was "horribly regretful." And so it goes.

It cannot be pretended that the primary cause of the problem is anything but medical malpractice. We hope that sometime it will be better recognized that the one sure way to end this debate is to eliminate wrongs, not rights.

The insurance industry has been successful in shielding its profitability and securing outrageous premium increases through clever advertising, through the print and electronic media, and by lobbying in the states for favorable legislation.

Their legislative efforts were rewarded with unprecedented activity. At no other time in the history of the United States have state legislatures moved with such unanimity or with greater rapidity than they did to confront the medical malpractice problem. Between 1974 and 1976, every state in the union passed some malpractice law, and while a number of these acts attempted to deal with only one or two specific issues, most frequently the legislation was of an omnibus nature.

Coupling their demands for confiscatory rate increases with threats that they would leave doctors uninsured, the insurers created, on their own, a potent pressure

point on the legislators. Furthermore, just as consumers bought the argument that no-fault would reduce their auto insurance rates, so did the doctors believe that "tort reforms," and specifically the "tort reforms" the insurers wanted, would solve their malpractice problems.

The insurance industry undertook this effort because it is worth millions to them, the potential dividends total billions of dollars. They saw the medical profession as the prime consumer, able to pay larger premiums, and well enough organized to pressure legislators to change laws. Their plan was to eliminate the right to recover fair and full reparation for injury. The insurance industry calls it the "drive for tort reform." However true, tort reform should eliminate torts or wrongs, not remedies or rights!

The methods of persuasion are obvious to us, but unfortunately not to the consumer. The medical profession is not the only "consumer" involved. Consumers should include all those who will avail themselves of medical services and facilities. The sad fact is that these consumers seldom realize that they are the targets, or that their rights are in jeopardy until they are themselves injured.

What the consumers do perceive from the barrage of publicity is that the insurance rates are sky-high, and that it is not the insurance company's fault. The insurance industry emphasized four main points:

1. That the court system is slow, inefficient, costly and a chancy way of getting recompense for injuries or damages.

2. That the huge verdicts by unbridled juries are driving insurance rates through the ceiling for all involved, and making some individuals uninsurable.

3. That trial lawyers, characterized as greedy and grasping, are the major culprits.

4. That the solution lies in changing the laws, State and federal, so that people will never need trial lawyers and will never need access to the courts.

The real tragedy is that this propaganda and pressure has caused legislators across the land to enact laws based on false and misleading statistics—laws which erode citizen's rights—laws which responded to insurance company profit priorities and to the medical establishment's factually unfounded assertion that the only way to solve the crisis was to make it difficult for people to be made whole when wronged!

What the public and the doctors have not been told in this long tale is the real reason for "tort reform." Let us again look at the casualty Insurance Industry. In twenty-five years prior to 1981 they suffered 13.8 billion dollars in underwriting losses! How did these losses affect them and their stockholders and their policyholders? The casualty insurance industry's assets increased in the same period—a small increase—from 23 billion dollars to over 197 billion dollars. These are their published figures. Do they sound like they need more help in their relentless crusade against human rights of their crusade against reparation for human wrongs?

The lack of information about the insurance process has not only caused people to make wrong decisions; it has also made them lose sight of how much or how little they actually know about the problem they are facing.

If the insurance industry is truly concerned with controlling the number of claims and accurately assessing the cost of claims paid, it should concern itself with the causes of medical malpractice. The doctors must face this problem as well.

The only cause of malpractice is negligence and as long as the medical profession is allowed to continue certain practices undeterred, the problem will grow in seriousness no matter how many band aids are applied to this reparations process.

The answer to malpractice cannot possibly be derived from the denial to an injured person of his right to seek reparation.

Because I know the committee will wish to have access to the best information available, I have included sufficient quantities for the members and staff a detailed analysis of A.M. Best's figures complete with graphs and charts showing what happens to medical malpractice premium dollars. As you know A.M. Best is an independent reporting service which publishes financial results of the experience of the insurance industry. The figures provided are gathered from the annual statements of the companies themselves.

Thank you.

Chairman JACOBS. Mr. Moore.

Mr. MOORE. Thank you, I thank both of you gentlemen.

Let me first ask Mr. Metzger, in your opinion why is it that hospitals and doctors do not now settle malpractice claims for pay-

ment for economic loss as they are encouraged to do under this bill?

Mr. METZGER. Sorry, didn't get the full question.

Mr. MOORE. Why are hospitals and doctors not settling malpractice claims now, as we would encourage them to do under this bill, rather than going to court?

Mr. METZGER. Why are they not?

Mr. MOORE. Yes.

Mr. METZGER. Well, Congressman Moore, I think therein lies one of our problems. I think that immediately when an offer is made by a defendant the plaintiff lawyer takes that as being the bottom line and so you have a floor and I think this was alluded to earlier in the day, what you do when you make that first offer, you encourage then the suspicion—and I have seen it for years and years—that my offering x dollars there must be y dollars in the pot.

So there is a little game which is being played and plaintiffs' lawyers and defense lawyers have continually engaged in that so the answer to the question is, reality. That is why. And also, I might add this: When an offer is made whatever we say about it, however we describe it, it is some admission of guilt.

Mr. MOORE. That has been your experience as a defense attorney?

Mr. METZGER. It sure has.

Mr. MOORE. What is the impact, as best you can tell from your experience with malpractice suits, on the defendant? Is the potential suit a deterrent to the defendant, whether it is a hospital or physician? Does it affect the way they act or conduct their practice?

Mr. METZGER. I think that the effect, psychological effect of a lawsuit on a defendant is a tremendous blow, I think it is the reason why we have heard today all of this testimony about defensive medicine. I think that there is no question about it from what I have seen.

Mr. MOORE. In your opinion, do you think the current system is really being equitable to the plaintiff and the defendant?

Mr. METZGER. I don't. I do not. I say that for this reason: In one case you have a tremendous award, $10.5 million, because you have excellent lawyers and you happen to hit an emotional chord in a particular jury. You may have the identical type situation handled by another law firm and you have a jury composed of people who are not responsive with possibly the end result of zero. I think that is wrong.

Mr. MOORE. Mr. Metzger, I want to compliment you for being here. I was once a defense counsel and we are not held in too high regard by our colleagues when we step up in advocating something that reduces the potential lawsuits and therefore potential income. So I compliment you for having the courage to step in here this morning when, in fact, the legal fraternity will probably chastize you when you return home for reducing the potential income of attorneys.

Mr. METZGER. Thank you.

Mr. MOORE. Mr. Bendorf, you certainly have made your point. We do intend to look at the insurance situation. One thing we are

reviewing is the fact that casualty companies invest, both professional malpractice and otherwise, premium income in tax-free investments for which they pay no income tax, and then use that tax-free income to pay claims for which they get tax deductions.

It appears that they get a double bite of the tax apple. That has not gone unnoticed to those of us on the Ways and Means Committee. That could be a contributing factor to what you point out and the figures you give us which are certainly helpful.

Let me ask you, what in your considerable amount of experience have you found is the average time across the country for recovery by the plaintiff in one of these malpractice suits?

Mr. BENDORF. I have to suggest that the studies, most of which were concluded by about 1978 including all the NAIC closed claims studies and others in the 1970's, indicate that virtually no cases ever go to trial.

Six percent of all the persons who enter hospitals are injured in the hospital and it is alleged that 2 percent of everyone who enters a hospital will be injured as a result of negligence and that numbers many millions of people.

There are probably about 10,000 trials a year. The total cost of the claims awarded per capita in the United States is not quite $2 and this is not quite comparable to the $1,425 per person that the total health care cost is represented to be.

The experience of the lawyers has been consistently that probably fewer than 1 out of 20 injured victims, negligently injured victims, ever seek help. Prior to the crisis in the early 1970's the lawyers rejected 9 of 10 of those as being viable suits. Since the publicity connected with medical malpractice which was the result of the so-called crisis in the early 1970's, they are seeing more people, rejecting more people, and not trying more cases.

So if there are, in fact, 10,000 trials a year there are about 2,000 successful plaintiffs because the defendant wins about 80 percent of the time in a medical malpractice suit. In medical malpractice, unlike other lines of insurance, the defense costs are very high per dollar of claim paid.

I don't have to tell you that I ridicule these figures about 27 cents and so on and I also am amused by the suggestion that plaintiffs' lawyers somehow or other like delay or like to roll the dice. Their record is not that good and no one can afford—who is not being paid—to extend a legal process.

Probably, 90 percent of the claims closed with payment are settled almost immediately; and probably only the most serious and most interesting and most difficult cases go to verdict.

This effort to make recovery unprofitable will certainly reduce the number of court cases at least for those individuals injured under medicare and medicaid, CHAMPUS, whatever, but whether or not they will not increase very substantially the utilization of this system remains to be seen.

Mr. MOORE. If I could interrupt, I have to leave to vote and I want to ask another question, so you can answer it for the record. To what extent are we denying fair treatment equitably under the law now because of access to the system based on income? One of the problems I ran into when I practiced law is the plaintiff who did not have the means to wait out the period from the time the

tort occurred until the time they won the case or received a settlement, very often could be sustained easier by people who had money than those who didn't. Very often, those without substantial resources had to settle prematurely for a far lesser sum because of economic pressures. I believe in my State it was considered a breach of legal ethics for the attorney to provide the funds or loan the funds to the patient.

Could you address that question in addition to finishing your answer to my first one which I appreciate. I do thank you both for being here.

Mr. BENDORF. The experience—first of all there is no statistical answer to the Congressman's question, and therefore I have to rely on the experience of those who share their experiences with me. The experience is certainly otherwise. The word "deny" is inappropriate because there is no denial. At the present time every citizen, and most State constitutions guarantee this, has access to the courts. The contingent fee guarantees that at least in a personal injury case the poor man will be as well represented as the rich man if he has a cause of action. This is unlike any other body of law.

So the experience that the Congressman indicated is exactly contrary to the experience I hear from trial lawyers all over the United States. That is, that the injured victim need not provide the funds necessary to adjudicate the case, gives him at least access to justice and sometimes even justice.

Chairman JACOBS. Mr. Bendorf, I heard Mr. Moore's question but I am not sure that exactly addresses it. He was addressing personal subsistence, not funds to defray legal cost and that the person did not have funds on hand for his or her subsistence and might agree to an unreasonably lower settlement than the person who could coast along on invested funds.

Mr. BENDORF. Ninety-one or ninety-two or ninety-three percent of the American public is covered by some hospitalization system. So you have to presume at the outset——

Chairman JACOBS. What percent was that?

Mr. BENDORF. In excess of 90 percent of the American population is covered by some sort of hospitalization.

Eighty percent of the American employed force is covered by some wage continuation plan. So as a general rule if there is someone who is bereft of all other resources, he is usually on public welfare. So it is unlikely that there will be someone who is not covered for his own personal experiences during the trial of the suit.

Chairman JACOBS. If he happens to be employed and part of the 80 percent.

Mr. BENDORF. If he is part of the employment force he is likely, 80 percent likely to have wage continuation of some sort.

Chairman JACOBS. Well, now, I would expect to hear President Reagan say that but I am surprised to hear you say that. You mean there are no people in this country who have run out of their unemployment compensation in this long recession we just went through?

Mr. BENDORF. No, I am not talking about unemployment compensation at all. I am talking about insurance plans for the continuation of wages as a result of an injury or other disability. I am

just giving you from the "Statistical Abstract of the United States" the universe of the American public.

Chairman JACOBS. Eighty percent of those now employed are insured for their wages to continue if they are out and hit by a car or have a malpractice?

Mr. BENDORF. That is correct.

Chairman JACOBS. That is a fact?

Mr. BENDORF. That is a fact. They have some kind of wage continuation plan.

Chairman JACOBS. What is the source of that fact?

Mr. BENDORF. The Statistical Abstract of the United States. I will be happy to Xerox those pages and present them to you.

[The information follows:]

USA Statistics in Brief

1984

A Statistical Abstract Supplement

U S Department of Commerce
BUREAU OF THE CENSUS

Population	Unit	1970	1975	1980	1981	1982
Total, incl Armed Forces abroad	Mil	204 4	216 0	227 1	229 8	232 1
Resident population	Mil	203 3	215 5	226 5	229 3	231 5
Per square mile	No	57 4	60 9	64 0	64 8	65 4
Under 5 years old	Mil	17 2	16 1	16 3	16 9	17 4
5-17 years old	Mil	52 5	51 0	47 4	46 2	45 4
18 years old and over	Mil	133 5	148 3	162 8	166 2	168 8
25-34 years old	Mil	24 9	31 3	37 1	38 8	39 3
35-44 years old	Mil	23 1	22 8	25 6	26 5	28 1
45-64 years old	Mil	41 8	43 8	44 5	44 5	44 5
65 years old and over	Mil	20 0	22 7	25 5	26 3	26 9
Median age	Yr	28 0	28 7	30 0	30 3	30 6
Male	Mil	98 9	104 9	110 1	111 4	112 5
Female	Mil	104 3	110 6	116 5	117 9	119 0
White	Mil	178 1	187 2	194 8	196 7	198 1
Black	Mil	22 6	24 7	26 6	27 2	27 6
Percent of resident population	Pct	11 1	11 5	11 8	11 8	11 9
American Indian	Mil	8	(na)	1 4	(na)	(na)
Persons of Spanish origin	Mil	9 1	(na)	14 6	(na)	(na)
Northeast	Mil	49 1	49 4	49 1	49 3	49 5
North Central	Mil	56 6	57 6	58 9	59 0	58 9
South	Mil	62 8	69 6	75 4	76 9	78 1
West	Mil	34 8	39 6	43 2	44 2	45 0
Urban	Mil	149 3	(na)	167 1	(na)	(na)
Rural	Mil	53 9	(na)	58 5	(na)	(na)
Metropolitan areas (MSA s)[1]	Mil	155 4	(na)	171 8	(na)	(na)
Percent of resident population	Pct	76 4	(na)	75 8	(na)	(na)
Central cities	Mil	71 9	(na)	72 4	(na)	(na)
Outside central cities	Mil	83 5	(na)	99 3	(na)	(na)
Nonmetropolitan areas	Mil	47 9	(na)	54 8	(na)	(na)
Males [2] Single	Pct	18 9	20 8	23 8	23 9	24 5
Married	Pct	75 3	72 8	68 4	67 8	67 2
Divorced	Pct	2 5	3 7	5 2	5 7	5 9
Females [2] Single	Pct	13 7	14 6	17 1	17 4	17 6
Married	Pct	68 5	66 7	63 0	62 4	61 9
Divorced	Pct	3 9	5 3	7 1	7 6	8 0
Households	Mil	63 4	71 1	80 8	82 4	83 5
Average size (persons)	No	3 14	2 94	2 76	2 73	2 72
One-person households	Pct	17 1	19 6	22 7	23 0	23 2
Families	Mil	51 6	55 7	59 6	60 3	61 0
Average size (persons)	No	3 58	3 42	3 29	3 27	3 25
With own children under 18 yrs old	Pct	55 9	54 0	52 1	51 8	50 8
White	Mil	46 3	49 5	52 2	52 7	53 3
Married couple	Pct	88 7	86 9	85 7	85 1	84 5
Female householder [3]	Pct	9 0	10 5	11 6	11 9	12 4
Black	Mil	4 9	5 5	6 2	6 3	6 4
Married couple	Pct	68 0	60 9	56 5	53 7	55 1
Female householder [3]	Pct	26 3	35 3	40 3	41 7	40 6
Immigrants	Thous	373	386	531	(na)	(na)
Rate per 1,000 population	Rate	1 8	1 8	2 3	(na)	(na)

(na) Not available [1] Metropolitan statistical areas as defined in June 1983 [2] Percent of total, 18 years old and over [3] With no spouse present

Vital Data	Unit	1970	1975	1980	1981	1982
Births, live	Thous	3 731	3 144	3 612	3 646	3 704
To unmarried women, percent of total	Pct	10 7	14 2	18 4	(na)	(na)
Per 1,000 population	Rate	18 4	14 6	15 9	15 9	16 0
White	Rate	17 4	13 8	14 9	(na)	(na)
Black	Rate	25 3	20 7	22 1	(na)	(na)
Deaths	Thous	1 921	1 893	1,990	1,967	1,986
Per 1,000 population	Rate	9 5	8 8	8 8	8 7	8 6
Infant deaths per 1,000 live births	Rate	20 0	16 1	12 6	11 7	11 2
White	Rate	17 8	14 2	11 0	(na)	(na)
Black	Rate	32 6	26 2	21 4	(na)	(na)
Deaths per 100,000 population	Rate	945	879	878	(na)	(na)
Diseases of heart	Rate	362	332	336	(na)	(na)
Malignancies	Rate	163	170	184	(na)	(na)
Cerebrovascular diseases	Rate	102	90	75	(na)	(na)
Accidents	Rate	56	48	47	(na)	(na)
Marriages	Thous	2 159	2 153	2,390	2 438	2,490
Per 1,000 population	Rate	10 6	10 0	10 6	10 6	10 8
Per 1,000 unmarried women, 15 & over	Rate	77	67	61	(na)	(na)
Divorces	Thous	708	1,036	1,189	1,219	1,180
Per 1,000 population	Rate	3 5	4 8	5 2	5 3	5 1
Per 1,000 married women, 15 & over	Rate	15	20	23	(na)	(na)

Health	Unit	1970	1975	1980	1981	1982
Life expectancy at birth: male	Yr	67 1	68 8	70 0	70 3	70 8
Life expectancy at birth: female	Yr	74 8	76 6	77 5	77 9	78 2
National health expenditures	$Bil	74 7	132 7	249 0	286 6	322 4
Per capita	Dol	358	604	1,075	1,225	1,385
Public, percent of total	Pct	37 2	42 3	42 3	42 6	42 4
Hospital care	$Bil	27 8	52 1	100 4	118 0	136 5
Physicians' services	$Bil	14 3	24 9	46 8	54 8	61 8
Nursing home care	$Bil	4 7	10 1	20 6	24 2	27 3
Private consumer expenditures for health	$Bil	41 6	69 1	129 1	148 9	167 0
Met by private insurance	Pct	37 5	43 6	44 2	44 9	45 8
Index of medical care prices (1967 = 100)	1967 = 100	120 6	168 6	265 9	294 5	328 7
Physicians' fees	1967 = 100	121 4	169 4	269 3	299 0	327 1
Hospital room rates	1967 = 100	145 4	236 1	418 9	481 1	556 7
Persons covered, private health insur [1]	Mil	159	178	189	188	(na)
Percent of civilian population	Pct	76 1	82 6	86 5	82 3	(na)
Physicians, active M D 's [2]	Thous	282	338	418	425	(na)
Rate per 100,000 population	Rate	138	156	182	184	(na)
Nurses, registered, active	Thous	750	961	1,273	(na)	(na)
Dentists, active [2]	Thous	96	107	121	124	(na)
Hospitals	Number	7 123	7 156	6 965	6 933	(na)
Beds per 1,000 population	Rate	7 9	8 8	8 0	8 0	(na)
Occupancy rate[3]	Rate	80 3	76 7	77 7	77 9	(na)
Days of hospital care per 1,000 persons[4]	Days	1 122	1,227	1,217	1,218	(na)
Bed disability days per person: Male	Days	5 2	5 4	5 9	5 8	(na)
Female	Days	6 9	7 6	8 0	7 9	(na)

(na) Not available [1] For hospital benefits [2] Excludes Federal practitioners [3] Ratio of average daily census to every 100 beds [4] Non-Federal short stay hospitals

Education	Unit	1970	1975	1980	1981	1982
School enrollment	Mil	60 4	61 0	57 3	58 4	57 9
Elementary (kindergarten & grades 1-8)	Mil	37 1	33 8	30 6	31 0	30 7
Secondary (grades 9-12)	Mil	14 7	15 7	14 6	14 6	14 1
Elementary & secondary in private school	Pct	10 8	10 1	(na)	10 1	10 5
Higher education	Mil	7 4	9 7	10 2	10 7	10 9
Female	Mil	3 0	4 4	5 2	5 4	5 5
School expenditures, total	$Bil	70 4	111 1	171 1	186 5	200 8
Elementary and secondary	$Bil	45 7	72 2	108 6	116 0	124 2
Public	$Bil	41 0	65 0	96 4	102 9	110 0
Average salary, public school teachers[1]	$Thous	8 6	11 7	16 0	17 6	19 1
High school graduates, yearly	Mil	2 9	3 1	3 1	3 0	(na)
College graduates, yearly	Mil	8	9	9	9	(na)
Adult persons completed high school [2]	Pct	55	63	69	70	71

Employment and Welfare	Unit	1970	1975	1980	1981	1982
Civilian labor force, 16 years and over	Mil	82 8	93 8	106 9	108 7	110 2
Female labor force	Mil	31 5	37 5	45 5	46 7	47 8
Employed	Mil	78 7	85 8	99 3	100 4	99 5
Unemployed	Mil	4 1	7 9	7 6	8 3	10 7
Unemployment rate	Pct	4 9	8 5	7 1	7 6	9 7
White	Pct	4 5	7 8	6 3	6 7	8 6
Black	Pct	9 4	14 8	14 3	15 6	18 9
Male	Pct	4 4	7 9	6 9	7 4	9 9
Female	Pct	5 9	9 3	7 4	7 9	9 4
Labor force participation rate						
Married men, spouse present	Pct	86 1	83 0	81 0	80 5	80 0
Married women, spouse present	Pct	40 8	44 4	50 1	51 0	51 2
With children under 6 years	Pct	30 3	38 7	45 1	47 8	48 7
Weekly earnings in private industry	Dol	120	164	255	255	267
Manufacturing	Dol	134	191	289	318	331
Services	Dol	97	135	191	209	225
Retail trade	Do	82	109	147	158	164
Index of productivity [3 5] (1977 = 100)	1977 = 100	86 2	94 5	98 9	101 3	101 2
Index of compensation per hour [4] (1977 = 100)	1977 = 100	58 2	85 5	131 2	143 9	155 1
Labor organization membership	Mil	21 9	[6] 23 4	22 8	(na)	(na)
Percent of nonfarm employed	Pct	30 8	[6] 29 9	25 2	(na)	(na)
Public social welfare expenditures	$Bil	145 9	290 0	483 4	(na)	(na)
Percent Federal	Pct	53 0	57 7	61 5	(na)	(na)
Social insurance	$Bil	54 7	123 0	229 6	(na)	(na)
Medicare	$Bil	7 1	14 8	35 0	(na)	(na)
Education	$Bil	50 8	80 9	120 6	(na)	(na)
Social Security beneficiaries	Mil	26 2	32 1	35 6	36 0	35 8
Total payments	$Bil	31 9	88 9	120 5	141 0	156 1
Avg monthly benefit [7] 1982 dol	Dol	293	371	389	410	419
Medicaid Recipients	Mil	14 5	22 2	21 6	22 1	(na)
Total payments	$Bil	4 8	12 3	23 3	27 3	(na)
Food stamps Participants	Mil	6 5	19 2	22 0	22 2	20 3
Federal Govt cost	$Bil	6	4 4	8 7	10 6	10 2
AFDC [8] Recipients	Mil	9 7	11 4	11 1	10 6	10 5
Total payments	$Bil	4 9	9 2	12 5	13 0	(na)

(na) Not available [1] Elementary and secondary schools only [2] Persons 25 years old and over [3] 1973 data [4] In private economy [5] Output per paid hour [6] 1974 data [7] Retired worker [8] Aid to Families with Dependent Children program

Income and Prices

	Unit	1970	1975	1980	1981	1982
Gross national product (GNP)	Bil	993	1,549	2,632	2,954	3,073
Per capita	Dol	4,841	7,173	11,596	12,848	13,239
Personal consumption expenditures	Bil	622	976	1,668	1,867	1,982
Gross private domestic investment	Bil	144	208	482	475	415
Net exports of goods and services	Bil	7	27	24	26	17
Govt. purchases of goods and services	Bil	220	340	536	586	648
National income	Bil	811	1,239	2,117	2,375	2,460
Personal income	Bil	811	1,266	2,165	2,435	2,579
Disposable personal income	Bil	695	1,096	1,839	2,048	2,177
Per capita	Dol	3,389	5,075	8,032	8,909	9,377
Personal savings	Bil	56	94	116	135	125
GNP, constant (1972) dollars	Bil	1,030	1,232	1,475	1,514	1,485
Per capita	Dol	5,021	5,702	6,478	6,584	6,399
GNP implicit price deflator, index	1972 = 100	96.4	125.8	178.4	195.1	206.9
Median family money income	Dol	9,867	13,719	21,023	22,388	23,433
White families	Dol	10,236	14,268	21,904	23,517	24,603
Black families	Dol	6,279	8,779	12,674	13,266	13,598
Median family income, 1982 dollars	Dol	24,529	24,604	24,626	23,761	23,433
Families below poverty level	Mil	5.3	5.5	6.2	6.9	7.5
Percent of all families	Pct	10.1	9.7	10.3	11.2	12.2
Persons below poverty level	Mil	25.4	25.9	29.3	31.8	34.4
Percent of all persons	Pct	12.6	12.3	13.0	14.0	15.0
Producer price index (PPI) [1]						
Crude materials	1967 = 100	112.3	196.9	304.6	329.0	318.5
Foodstuffs and feedstuffs		112.8	191.8	259.2	257.4	247.8
Nonfoods, excl. fuels		109.6	188.3	346.1	413.7	376.8
Fuel		122.6	271.5	615.0	751.2	688.1
Intermediate materials		109.9	160.0	260.3	308.0	310.4
Finished goods		110.3	165.4	247.0	280.8	280.6
PPI, all commodities		110.4	174.9	268.8	293.4	290.3
Consumer price index, all items	1967 = 100	116.3	161.2	246.8	272.4	289.1
Fuel oil, coal and bottled gas		110.1	235.3	566.0	675.9	667.9
Homeownership cost [2]		128.5	161.7	314.0	352.7	376.8
Gas and electricity		107.3	169.6	391.8	345.9	383.8
Medical care		120.6	168.6	265.9	294.5	328.7
Transportation		112.7	150.6	249.7	280.0	291.5
Food		114.9	175.4	254.6	274.6	285.7
Rent		110.1	137.3	191.6	209.2	224.0

Law Enforcement

	Unit	1970	1975	1980	1981	1982
Violent crimes against persons	Thous	739	1,039	1,309	1,322	1,286
Per 100,000 inhabitants	Rate	364	462	581	577	555
Murders, manslaughters [3]	Thous	16	21	23	23	21
Robberies	Thous	350	465	548	574	537
Property crimes	Thous	7,359	10,230	11,987	11,966	11,572
Per 100,000 inhabitants	Rate	3,621	4,600	5,319	5,223	4,990
Victimization rates: Violent crime [4]	Rate	(na)	32.6	33.3	36.3	34.3
Larceny-theft [4]	Rate	(na)	86.0	83.0	85.1	82.5
Burglary [5]	Rate	(na)	91.7	84.3	87.9	78.2
Larceny [5]	Rate	(na)	125.4	138.5	121.0	113.9

(na) Not available. [1] By stage of processing. [2] Includes home purchase, interest, taxes, insurance, maintenance, and repairs. [3] Nonnegligent manslaughter. [4] Per 1,000 persons, 12 years old and over. [5] Per 1,000 households.

Federal Government

	Unit	1970	1975	1980	1981	1982
Budget receipts	Bil	192.8	279.1	517.1	599.3	617.8
Individual income taxes	Pct	46.9	43.9	47.2	47.7	48.2
Income tax per capita	Dol	413	594	1,102	1,230	(na)
Corporation income taxes	Pct	17.0	14.6	12.5	10.2	8.6
Budget outlays	Bil	195.7	324.2	576.7	657.2	728.4
In constant (1972) dollars	Bil	220.2	280.2	316.7	327.5	336.7
Defense	Pct	40.1	26.4	23.6	24.3	25.7
Nondefense	Bil	117.1	258.7	440.8	497.4	541.6
Deficit	Bil	-2.8	-45.2	-59.6	-57.9	-110.6
Gross debt outstanding	Bil	380	544	914	1,004	1,147
Federal civilian employment (Dec.)	Thous	2,846	2,741	2,772	2,722	2,724
Voter participation in national elections [1]	Pct	460.2	453.5	52.6	(x)	(x)

State and Local Government

	Unit	1970	1975	1980	1981	1982
General revenue, total [2]	Bil	139.8	228.2	382.3	423.4	466.2
From own taxes	Bil	86.8	141.5	253.5	284.5	306.3
Property	Pct	39.3	36.4	30.6	30.7	30.6
Sales and gross receipts	Pct	34.9	35.2	36.7	36.2	35.1
From Federal Government	Pct	16.7	20.6	21.7	21.3	19.0
Direct general expenditure, total	Bil	131.3	226.7	387.3	405.6	433.5
Education	Pct	40.1	38.3	38.3	35.9	35.7
Public welfare	Pct	11.2	12.3	12.9	13.3	13.0
Health and hospitals	Pct	7.4	8.2	8.8	8.9	9.3
Debt outstanding (end of fiscal year)	Bil	143.6	219.9	335.6	382.9	399.3
Long-term debt retired	Bil	7.0	10.9	17.4	18.9	21.0
Government employment (Oct.) [3]	Mil	8.5	10.1	11.0	10.9	10.8

National Defense

	Unit	1970	1975	1980	1981	1982
Federal outlays for national defense	Bil	78.6	85.6	135.9	159.8	187.4
Percent of gross national product	Pct	8.1	5.8	5.3	5.6	6.2
U.S. military personnel on active duty	Thous	3,066	2,138	2,051	2,083	2,109
Veterans, living	Mil	27.6	29.5	30.1	30.1	29.5
On compensation and benefit rolls [4]	Mil	4.7	4.9	4.6	4.5	4.4

Science and Energy

	Unit	1970	1975	1980	1981	1982
Science funds for research and develop.	Bil	26.1	35.2	62.7	72.1	79.0
In constant (1972) dollars	Bil	26.6	28.2	35.2	36.9	38.0
Percent of gross national product	Pct	2.6	2.3	2.4	2.5	2.6
Basic research	Bil	3.5	4.6	8.1	9.2	9.7
Energy production (Btu)	Quad	62.5	60.1	64.8	64.4	63.6
Energy imports (Btu)	Quad	8.4	14.1	16.0	13.9	12.0
Energy consumption (Btu)	Quad	66.8	70.7	78.0	74.0	70.9
Crude oil production, domestic [5]	Mil bbl	3,517	3,057	3,146	3,129	3,165
Imports of crude oil [5]	Mil bbl	483	1,466	1,926	1,605	1,263
Percent OPEC [6]	Pct	48.8	78.2	73.4	66.5	49.7
Natural gas production, cu. ft.	Tril	21.9	20.1	20.4	20.2	18.5
Coal production, short tons	Mil	613	665	830	824	839
Electric energy production (utility)	Bil	1,640	2,093	2,286	2,288	2,341
Percent nuclear	Pct	1.4	8.0	11.0	11.9	12.6

(na) Not available. (x) Not applicable. [1] Percent of voting-age population casting votes for President. [2] 1972 data. [3] 1978 data. [4] Includes intergovernmental. [5] Full-time equivalent. [6] Includes servicent. [7] Barrels of 42 gallons. [8] Organization of Petroleum Exporting Countries.

Business and Finance	Unit	1970	1975	1980	1981	1982
Proprietorships and partnerships, number	Mil	10.3	12.0	14.1	(na)	(na)
Receipts	$Bil	331	467	786	(na)	(na)
Corporations, number active	Mil	1.7	2.0	2.7	(na)	(na)
Receipts	$Bil	1,751	3,199	6,381	(na)	(na)
Index of net business formation	1967 = 100	106	107	122	119	113
Industrial and commercial failures	Thous	10.7	11.4	11.7	16.8	(na)
Current liabilities	$Bil	1.9	4.4	4.6	7.0	(na)
Gross private domestic investment	$Bil	144	205	402	475	415
In constant (1972) dollars	$Bil	159	156	209	229	195
Expenditures for new plant and equipment	$Bil	105.6	157.7	295.6	321.5	316.4
Corporate profits after taxes	$Bil	41.3	81.5	149.8	144.1	115.1
Corporate capital consumption allowances	$Bil	56.6	89.4	163.0	191.9	220.9
Profit rate to stock equity, mfg. corp	Pct	9.3	11.6	13.9	13.6	9.3
Industrial production index	1967 = 100	108	116	147	151	139
Manufacturing output related to capacity	Pct	80	73	80	79	71
Value added by manufacture	$Bil	300	442	774	838	(na)
Average employment in manufacturing	Mil	19	18	21	20	(na)
Raw steel production, short tons	Mil	132	117	112	121	75
Manufacturing and trade sales, avg. mo.	$Bil	107	162	327	356	344
Manufacturing and trade inventories	$Bil	178	288	480	526	512
Inventory-sales ratio	Ratio	1.62	1.57	1.45	1.44	1.51
Retail stores, sales	$Bil	368	566	963	1,046	1,076
New construction, value	$Bil	95	136	231	239	232
Residential, incl. farm	$Bil	32	46	67	67	75
In constant (1977) dollars	$Bil	168	152	161	158	151
New housing units started	Thous	1,469	1,171	1,313	1,100	1,072
Commercial banks: Assets	$Bil	582	975	1,544	1,682	1,878
Loans, gross	$Bil	300	513	842	933	1,033
Deposits	$Bil	486	783	1,194	1,279	1,406
Savings and loan assns: Assets	$Bil	176	336	630	664	705
Savings capital	$Bil	146	285	511	525	566
Demand deposits and currency	$Bil	215	289	383	399	373
Time deposits[1]	$Bil	414	730	1,153	1,199	1,219
Credit market debt outstanding	$Bil	2,185	2,625	4,703	5,399	5,888
Consumer credit outstanding	$Bil	143	223	368	412	431
Mortgage debt outstanding	$Bil	474	896	1,472	1,583	1,682
Residential nonfarm	Pct	75.5	73.9	76.4	75.9	75.6
Money market rates: Corporate bonds Aaa	Pct	8.04	8.83	11.94	14.17	13.79
Treasury bills, 3-month	Pct	6.39	5.77	11.43	14.03	10.61
Home mortgages, conventional, new	Pct	8.52	9.10	13.95	16.52	15.79
Prime rate charged by banks	Pct	7.9	7.9	15.3	18.9	14.9
NYSE common stock index: mo. avg.[2]	Index	46	46	98	74	89
Dow-Jones industrial (30 stocks), mo. avg.	Index	753	820	891	933	884
Mutual funds, assets	$Bil	48	46	135	241	297
Life insurance companies: Assets	$Bil	207	289	479	526	588
Life insurance in force	$Bil	1,402	2,140	3,541	4,084	4,477

(na) Not available [1] Savings and small denomination time deposits. [2] Index base: Dec. 31, 1965 = 50

Agriculture	Unit	1970	1975	1980	1981	1982
Farm population[1]	Mil	9.7	8.9	7.2	6.9	6.9
Farms[2]	Thous	2,948	2,521	2,428	2,434	2,400
Average acres per farm[2]	No.	374	420	453	439	433
Gross farm income	$Bil	56.6	109.6	150.1	167.1	162.3
Crops	$Bil	21.0	45.8	72.7	73.1	74.4
Livestock	$Bil	29.5	43.1	67.8	68.2	70.3
Net farm income	$Bil	14.4	25.6	21.5	30.1	22.1
Average per farm[2]	$Thous.	14.9	10.1	8.9	12.3	9.2
Farm output per unit of total input, index	1977 = 100	87	99	101	115	116
Crop production per acre, index	1977 = 100	88	95	99	113	115
Corn production, bushels	Bil.	4.2	5.8	6.6	8.2	8.4
Wheat production, bushels	Bil.	1.4	2.1	2.4	2.8	2.8
Beef production, pounds	Bil.	21.7	24.0	21.6	22.4	22.5

Communications and Transportation	Unit	1970	1975	1980	1981	1982
Postal service revenues	$Bil	7.7	11.6	19.1	20.8	23.6
Postal service surplus (+) or deficit (-)	$Mil	-165	-686	-395	-588	+837
Pieces of mail per capita	No.	412	415	475	477	480
Telephone systems, operating revenues	$Bil	18.2	31.3	56.6	63.7	(na)
Cable television subscribers	Mil	4.5	9.8	15.5	18.3	21.9
Commercial broadcast revenues: [3] Radio	$Bil	1.1	1.7	3.2	(na)	(na)
Television	$Bil	2.8	4.1	8.8	(na)	(na)
Daily newspapers	No.	1,748	1,756	1,745	1,730	1,711
Net paid circulation	Mil	62.1	60.7	62.2	61.4	62.5
Motor vehicle registrations	Mil	108	133	156	159	160
New pass. car sales: [4] Domestic	Mil	7.1	7.1	6.6	6.2	5.8
Imports	Mil	1.3	1.6	2.4	2.3	2.2
Motor vehicle deaths	Thous.	54.6	45.9	53.3	51.5	46.3
Intercity passenger traffic: [5]	Bil.	1,181	1,354	1,599	1,574	1,610
By private automobile	Pct.	86.9	86.5	82.4	83.8	83.5
Intercity freight traffic: [6]	Bil.	1,936	2,086	2,487	2,443	2,252
Moved by railroads	Pct.	39.8	38.7	37.4	37.8	36.1
Cargo tonnage of waterborne commerce	Mil.	1,532	1,665	1,889	1,941	(na)
Operating revenues: Railroads [7]	$Bil.	12.0	16.4	29.1	30.7	27.5
Domestic air carriers [8]	$Bil.	7.1	11.9	26.4	28.8	28.7
Revenue passengers: Domestic airlines [8]	Mil.	153	188	273	266	273
Bus lines, intercity	Mil.	401	351	385	375	389
Local transit	Mil.	5,892	5,643	6,447	6,276	6,036

Foreign Commerce	Unit	1970	1975	1980	1981	1982
Balance on current account	$Bil.	2.3	18.1	4	4.6	-11.2
Balance on merchandise trade	$Bil.	2.6	8.9	-25.5	-28.1	-36.4
U.S. direct investment abroad	$Bil.	75.5	124.1	215.4	226.4	221.3
Foreign direct investment in U.S.	$Bil.	13.3	27.7	68.4	80.4	101.8
U.S. foreign economic and military aid	$Bil.	6.6	6.9	9.7	10.8	12.3
Domestic exports of merchandise	$Bil.	42.6	108.6	216.7	229.0	207.2
Agricultural	$Bil.	7.3	21.9	41.2	43.3	38.6
Machinery	$Bil.	11.7	29.2	57.3	64.4	59.9
General imports of merchandise	$Bil.	40.0	96.6	244.9	261.3	244.0
Petroleum and products	$Bil.	2.8	24.8	77.6	75.6	59.4

(na) Not available [1] Based on 1981 census farm definition. [2] Beginning 1975, based on 1974 census farm definition. [3] Net revenues. [4] Retail sales. Imports exclude domestic models produced in Canada. [5] Passenger miles. [6] Ton-miles. [7] Class I only. [8] Certificated route carriers only.

Selected Data — Regions and States

Region, Division, State	Rank	Population,[1] 1982 Total (mil.)	Population,[1] 1982 As a % of U.S.	Population,[1] 1988 Total (proj.)	Population,[1] 1988 Percent Black	Percent change in population, 1980–1988	Median household income, 1987 ($)	Total personal income, 1987 ($ bil.)	Per capita personal income, 1987 ($)	Total personal income, 1988 (proj.) ($ bil.)	Per capita personal income, 1988 (proj.) ($)
U.S.	(x)	231.5	85	226.5	11.7	6.4	25,986	5,553	9.7	11,107	19,917
Northeast	(x)	49.5	304	49.1	9.9	5.3	28,851	5,299	9.0	12,004	20,651
No. Central	(x)	58.9	78	58.9	9.1	2.2	26,561	4,981	11.1	10,976	20,988
South	(x)	78.1	90	75.4	18.6	5.9	23,138	5,401	8.9	10,229	17,857
West	(x)	45.0	26	43.2	5.2	14.5	27,626	6,875	9.9	11,814	20,974
Ala	22	3.9	78	3.9	25.6	9	23,982	4,634	14.4	8,648	16,347
Alaska	50	.4	1	.4	3.4	2.4	43,446	6,213	9.9	16,257	26,385
Ariz	29	2.9	25	2.7	2.8	16.2	25,432	7,131	9.9	10,173	19,017
Ark.	33	2.3	44	2.3	16.3	.8	20,724	3,872	9.6	8,479	14,641
Calif.	1	24.7	158	23.7	7.7	19.2	29,459	7,285	9.9	12,967	21,537
Colo.	27	3.0	29	2.9	3.5	11.8	30,953	7,099	7.7	12,302	21,279
Conn.	26	3.2	647	3.1	7.0	4.0	32,771	5,427	6.9	13,748	23,149
Del.	47	.6	312	.6	18.1	1.6	27,630	6,396	8.5	11,731	20,817
D.C.	(x)	.6	(*)	.6	70.3	2.6	100,000	10,800	10.6	14,560	19,089
Fla.	7	10.4	192	9.7	13.8	8.8	20,329	7,466	9.2	10,978	17,260
Ga.	12	5.6	97	5.5	28.8	1.1	22,433	5,215	7.8	9,583	17,414
Hawaii	39	1.0	155	1.0	1.8	7.4	29,000	6,584	6.7	11,852	22,750
Idaho	40	1.0	12	.9	.3	3.9	18,328	4,063	9.6	9,029	17,482
Ill.	5	11.4	206	11.4	14.7	5.6	31,722	4,817	11.3	12,100	22,748
Ind.	14	5.5	152	5.5	7.6	1.6	27,527	4,438	11.9	10,081	20,535
Iowa	28	2.9	52	2.9	1.4	.9	24,020	4,137	8.5	10,791	20,062
Kans.	32	2.4	29	2.4	5.3	2.7	26,866	4,852	8.3	11,765	19,707
Ky.	23	3.7	92	3.7	7.1	.7	23,080	5,311	10.2	10,231	18,088
La.	18	4.4	98	4.2	29.4	2.4	23,818	5,311	10.2	10,231	18,088
Maine	38	1.1	37	1.1	3	4	23,560	3,880	8.6	9,042	16,167
Md.	19	4.3	434	4.2	22.7	1.5	33,033	6,012	8.4	12,238	23,112
Mass.	11	5.8	739	5.7	3.9	2.5	31,274	5,504	7.9	12,089	21,188
Mich.	8	9.1	160	9.3	12.9	1.8	28,411	6,785	15.5	10,956	22,107
Minn.	21	4.1	52	4.1	1.3	.8	29,431	4,455	7.8	11,175	21,185
Miss.	31	2.6	54	2.5	35.2	1.0	20,454	3,573	11.0	7,778	14,591
Mo.	15	5.0	72	4.9	10.5	1.1	25,540	4,948	9.2	10,170	18,784
Mont.	44	.8	6	.8	2	1.3	24,053	4,333	8.8	9,580	18,413
Nebr.	35	1.6	21	1.6	3.1	1.8	25,451	3,951	6.1	10,883	19,122
Nev.	43	.9	8	.8	6.4	6.7	29,021	7,801	10.1	11,981	21,311
N.H.	42	1.0	105	.9	4	.8	29,565	3,829	7.4	10,729	19,723
N.J.	9	7.4	996	7.4	12.6	6.7	35,226	6,676	9.0	13,089	22,906
N. Mex.	37	1.4	11	1.3	1.8	3.6	23,559	6,808	9.2	9,180	16,936
N.Y.	2	17.7	373	17.6	13.7	9.5	27,426	6,488	8.6	12,314	20,180
N.C.	10	6.0	123	5.9	22.4	1.0	23,545	4,543	9.0	9,044	16,792
N. Dak.	46	.7	10	.7	4	.8	25,939	2,648	5.9	10,872	18,023
Ohio	6	10.8	260	10.8	10.0	1.1	28,934	4,936	12.5	10,677	20,909
Okla.	25	3.2	46	3.0	6.8	1.9	27,040	5,222	5.7	11,370	17,888
Oreg.	30	2.6	28	2.6	1.4	2.5	27,027	6,567	11.5	10,335	20,087
Pa.	4	11.9	264	11.9	8.8	1.3	24,836	3,453	10.9	10,988	19,886
R.I.	41	1.0	908	.9	2.9	2.1	27,902	5,384	10.2	10,723	19,448
S.C.	24	3.2	108	3.1	30.4	1.1	23,818	5,381	10.8	8,502	16,979
S. Dak.	45	.7	9	.7	3	.8	23,818	2,645	5.5	9,686	15,985
Tenn.	17	4.7	113	4.6	15.8	.7	24,826	4,414	11.8	8,906	16,564
Tex.	3	15.3	58	14.2	12.0	21.3	29,458	6,302	8.9	11,419	18,618
Utah	36	1.6	19	1.5	.9	4.1	27,224	5,334	7.8	8,875	20,024
Vt.	48	.5	58	.5	.2	.8	22,568	4,622	6.9	9,507	17,205
Va.	13	5.5	139	5.3	18.9	1.5	27,678	4,258	7.7	11,085	20,016
Wash.	20	4.2	84	4.1	2.6	2.9	29,470	6,282	12.1	11,580	21,686
W. Va.	34	1.9	81	1.9	3.3	.7	23,818	2,511	13.9	8,769	17,309
Wis.	16	4.8	88	4.7	3.9	1.3	28,632	4,439	10.7	10,774	20,915
Wyo.	49	.5	5	.5	.7	5.2	25,433	4,804	5.8	12,372	22,400

(x) Not applicable. [1] Preliminary estimates as of July 1. [2] Of land area. [3] As of April 1. [4] Refers to metropolitan statistical areas as defined June 30, 1983. [5] Overseas per 100,000 population. [6] 10,016

Sources of Data — U.S. Government

Agency for International Development: Foreign aid

Bureau of the Census: Population and households; education (employment, school years completed); family income; poverty; voter participation; State and local govts.; mfg. profit ratio by sales; mfg. value added and employment; mfg. and trade sales and inventories; construction; total retail sales; imports and exports; housing

Bureau of Economic Analysis: GNP; national income and personal income; business investment and profits; index of net business formation; foreign investment; international transactions

Bureau of Justice Statistics: Victimization rates

Bureau of Labor Statistics: Labor force; employment; unemployment; and participation rate; weekly earnings; productivity; compensation and price indexes; labor organization membership

Corps of Engineers: Waterborne commerce

Dept. of Agriculture: Food stamp recipients and payments; farm population; farming; farm income; productivity; production and exports

Dept. of Defense: Military personnel

Dept. of Energy: Energy production; imports; consumption; oil production and imports; natural gas; coal; and electric energy production

Federal Aviation Administration: Air carrier revenues and passengers

Federal Bureau of Investigation: Crime

Federal Communications Commission: Telephone and commercial broadcast revenues

Federal Deposit Insurance Corporation: Commercial banks

Federal Highway Administration: Vehicle registrations

Federal Home Loan Bank Board: Savings and loan associations

Federal Reserve Board: Industrial production; mfg. output/capacity; money supply; interest rates; credit market debt; mortgage debt and consumer credit outstanding

Health Care Financing Administration: Health expenditures; Medicaid recipients and payments

Immigration and Naturalization Service: Immigrants

Internal Revenue Service: Business units and receipts

National Center for Education Statistics: School expenditures; graduates

National Center for Health Statistics: Births; deaths; marriages; divorces; life expectancy; health personnel; uses of hospital care; total disability days

National Science Foundation: R & D funds

Office of Management and Budget: Federal finances

Office of Personnel Management: Federal civilian employment

Postal Service: Postal service finances and mail volume

Social Security Administration: Social welfare expenditures; Social Security and AFDC recipients and payments

Veterans Administration: Veterans

Non-Government Agencies

Alan Guttmacher Institute: Abortions

American Bus Association: Intercity bus passengers

American Council on Life Insurance: Life insurance

American Hospital Association: Hospitals and beds

American Iron and Steel Institute: Steel production

American Public Transit Association: Local transit passengers

Association of American Railroads: Railroad revenue

Dun and Bradstreet, Inc.: Business failures

Editor and Publisher Yearbook: Newspapers

Health Insurance Association of America: Health insurance coverage

Investment Company Institute: Mutual funds

Motor Vehicle Manufacturers Association: Automobile retail sales

National Education Association: Teachers' salaries

National Safety Council: Motor vehicle deaths

Television Digest, Inc.: Cable television

Transportation Policy Association: Inter-city traffic

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National Data Book and
Guide to Sources

STATISTICAL ABSTRACT OF THE UNITED STATES 1984

104th Edition

U.S. Department
of Commerce
BUREAU OF
THE CENSUS

No. 155. Persons With Health Care Coverage by Type of Coverage, 1980 and 1981, and by Poverty Status and Age, 1981

[In thousands. Persons as of March of following year who had coverage in year shown. See headnote, table 610. See also tables 636 and 641. For explanation of poverty level, see text, p.447]

TYPE OF COVERAGE	1980, total	1981					
		Total	Below poverty level	Above poverty level	Under 18 yrs. old	18-64 years old	65 yrs. old and over
Medicare, total [1]	26,200	27,208	4,454	22,754	52	2,886	24,271
Medicare only	20,207	20,821	2,733	18,088	18	1,632	19,171
Medicare and other health plans [2]	2,451	2,703	100	2,603	10	564	2,129
Medicaid, total	18,968	19,407	11,687	7,720	8,147	8,179	3,081
Medicaid only	12,239	12,701	9,213	3,488	6,797	5,904	-
Medicaid and Medicare only	3,541	3,685	1,621	2,064	23	690	2,971
Medicaid and group health plan [2] only	2,673	2,523	701	1,822	1,187	1,336	-
Medicaid and other health plans	514	499	151	348	139	250	110
Employer or union provided group health plan	137,307	136,740	5,154	131,586	39,894	94,942	1,904
Employer or union helped pay for plan	130,134	130,436	4,858	125,778	38,039	90,591	1,806
Paid for all of plan	58,107	58,096	1,753	56,343	16,014	41,193	888
Paid for part of plan	72,027	72,340	2,905	69,435	22,025	49,398	918
Employer or union did not help pay	7,173	6,304	495	5,809	1,855	4,351	99
CHAMPUS [4], V.A.[5] or military health care	8,456	10,432	747	9,685	2,641	7,081	710

- Represents zero or rounds to zero. [1] Includes Medicaid and Medicare only, shown under Medicaid. [2] Excluding Medicaid. [3] Employer or union provided. [4] Civilian Health and Medical Program of the Uniformed Services. The Dept. of Defense operates this program to provide reimbursement (after payment of a deductible) for covered medical care rendered in civilian facilities to wives and children of active military personnel, to retired military personnel and their dependents, and to dependents of deceased personnel. Program is designed for those unable to use Government medical facilities for reasons of distance, overcrowding, or the unavailability of appropriate treatment at a military medical center. [5] Veterans Administration.

Source: U.S. Bureau of the Census, *Current Population Reports*, series P-60, Nos. 131 and 136.

No. 156. Health Insurance Coverage, by Type of Coverage: 1960 to 1981

[In millions of persons. Beginning 1975, data include Puerto Rico and other U.S. territories and possessions. Duplication eliminated except as noted. "Hospital," "Surgical," "Regular medical," and "Major medical" represent coverage by insurance companies, Blue Cross-Blue Shield and medical society approved plans, and other plans. "Dental" represents insurance company coverage only. "Disability income" represents coverage by insurance companies, paid sick leave plans, and employee organizations. See also table 158]

YEAR AND AGE GROUP	Hospital	Surgical	Regular medical	Major medical	DISABILITY INCOME [1]		Dental
					Short term	Long term	
1960	122.5	111.5	83.2	32.6	42.4	1[2]	(NA)
1965	136.7	130.5	109.6	69.7	46.9	4.5	(NA)
1970, total	158.6	151.4	136.7	103.5	58.1	11.0	12.0
Under 65	148.7	142.8	130.4	(NA)	58.1	11.0	(NA)
65 and over	10.1	8.6	6.3	(NA)	-	-	(NA)
1975, total	178.0	168.9	161.9	134.1	63.0	18.4	30.2
Under 65	165.4	156.5	152.2	(NA)	(NA)	18.4	(NA)
65 and over	12.6	10.4	9.7	(NA)	(NA)	-	(NA)
1979, total	184.1	174.7	164.8	147.6	65.6	19.9	70.2
Under 65	169.1	163.4	154.3	144.7	(NA)	19.9	(NA)
65 and over	15.0	11.3	10.5	2.9	(NA)	-	(NA)
1980, total	189.0	178.2	169.5	155.2	65.4	21.1	77.9
Under 65	172.5	166.1	158.0	152.0	(NA)	21.1	(NA)
65 and over	16.5	12.1	11.5	3.2	(NA)	-	(NA)
1981, total	188.3	176.9	163.9	157.7	60.3	21.7	86.5
Under 65	172.7	165.6	153.3	154.5	(NA)	21.7	(NA)
65 and over	15.6	11.3	10.6	3.2	(NA)	-	(NA)

- Represents zero. NA Not available. [1] Any duplication resulting from combinations for short-term and long-term protection has not been eliminated. [2] Included in "short-term" with some possible duplication.

Source: Health Insurance Association of America, Washington, D.C., *Sourcebook of Health Insurance Data*, annual.

No. 157. Persons Covered by Private Health Insurance: 1967 to 1979

TYPE OF CARE	PERCENT UNDER 65 YEARS						PERCENT 65 YEARS AND OVER					
	1967	1970	1975	1977	1978	1979	1967	1970	1975	1977	1978	1979
Hospital care	77.0	78.6	78.1	79.2	79.2	79.5	45.0	51.4	62.7	67.3	66.4	64.1
Physicians' services:												
Surgical services	75.2	76.9	77.9	78.1	78.5	79.3	44.1	48.7	55.0	49.7	42.4	42.8
In-hospital visits	65.6	75.1	79.6	78.3	79.2	80.4	31.1	41.1	42.8	42.1	44.0	44.0
X-ray and laboratory exams	50.0	73.8	78.2	71.6	73.6	80.0	18.7	37.4	37.1	37.2	37.4	42.4
Office and home visits	(NA)	35.2	63.9	61.2	66.7	65.1	(NA)	17.3	26.8	26.5	26.4	26.5
Dental care	2.6	6.5	15.5	22.6	27.0	30.2	.4	.6	2.4	4.8	6.6	6.1
Prescribed drugs (out-of-hospital)	39.0	53.5	76.1	66.2	66.2	65.2	9.7	15.9	21.8	18.2	18.8	17.5
Private duty nursing	41.5	53.1	74.3	65.8	67.5	63.4	11.7	15.8	21.7	15.7	14.2	14.1
Visiting nurse service	44.6	56.4	71.8	65.7	69.1	78.4	13.0	18.8	24.1	18.2	26.8	33.7
Nursing home care	8.9	15.4	34.6	29.7	39.3	44.0	15.2	24.7	19.8	23.3	35.1	47.8

NA Not available.

Source: U.S. Health Care Financing Administration, *Health Care Financing Review*, Fall 1981. Data for 1967-1975 published by U.S. Social Security Administration in *Social Security Bulletin*, September 1978, and earlier issues.

No. 158. Private Health Insurance—Persons Covered for Specified Benefits: 1960 to 1981

[In millions, except percent. As of December 31. For persons covered under Federal Government programs, see tables 155, 638, and 641-643. Data for other plans from Survey of Independent Prepaid and Self-Insured Health Plans; see Appendix III. HIAA = Health Insurance Association of America. See *Historical Statistics, Colonial Times to 1970*, series B 401-412, for persons covered]

Benefit and type of plan	1960	1965	1970	1975	1977	1978	1979	1980	1981
Hospital benefits; persons covered:									
Estimate, household survey (net) [1]	[2] 129.8	[2] 145.5	154.1	162.4	168.4	169.1	170.8	(NA)	(NA)
Percent of population covered [4]	[2] 70.0	[2] 73.9	75.7	75.5	76.8	76.2	76.1	(NA)	(NA)
Estimate by HIAA (net) [5 6]	122.5	138.7	158.8	178.0	179.0	[7] 184.7	[7] 184.1	[7] 189.0	[7] 188.3
Percent of population covered [4]	68.2	71.9	78.1	82.8	81.6	83.3	82.1	83.3	82.3
Blue Cross-Blue Shield plans, gross	57.5	83.7	75.5	85.8	85.1	85.3	85.4	(NA)	(NA)
Insurance companies, gross [8]	78.6	87.0	107.2	117.3	105.1	111.7	109.8	(NA)	(NA)
Group policies [8]	54.4	63.0	80.5	87.2	78.4	75.6	75.5	(NA)	(NA)
Individual policies	22.2	24.0	26.7	30.1	26.7	[7] 36.2	[7] 34.6	[7] 34.1	[7] 25.6
Other plans, gross [9 10]	6.0	7.0	8.1	13.1	18.3	21.5	25.5	(NA)	(NA)
Surgical benefits, persons covered:									
Estimate, household survey (net) [1]	[2] 120.5	[2] 142.1	150.0	160.2	161.7	161.9	165.1	(NA)	(NA)
Percent of population covered [4]	[2] 65.0	[2] 72.2	73.7	74.5	73.7	73.0	73.6	(NA)	(NA)
Estimate by HIAA (net) [5 6]	111.5	130.5	151.4	168.9	167.2	[7] 173.3	[7] 174.7	[7] 178.2	[7] 176.9
Percent of population covered [4]	62.0	67.7	74.4	78.6	76.2	78.1	77.9	78.6	77.3
Blue Cross-Blue Shield plans, gross	48.3	58.3	69.1	77.8	75.4	74.4	73.5	(NA)	(NA)
Insurance companies, gross [8]	71.5	83.2	99.5	106.4	93.0	94.6	95.3	(NA)	(NA)
Group policies [8]	55.5	65.5	81.5	88.0	78.6	77.6	77.6	(NA)	(NA)
Individual policies	16.0	17.7	18.0	18.5	14.4	[7] 16.9	[7] 17.9	[7] 17.6	[7] 12.4
Other plans, gross [9 10]	7.3	8.7	10.5	15.8	21.5	25.0	29.1	(NA)	(NA)
Major medical expense: [6 7 11]									
Total persons covered, net	32.6	69.7	103.5	134.1	139.4	141.5	147.6	155.2	157.7
Insurance companies, net	25.4	53.0	77.1	92.2	98.0	102.5	104.5	107.2	107.4
Group policies, net	24.4	49.7	73.7	87.0	91.7	96.1	99.8	102.5	103.3
Individual and family policies	1.6	4.5	5.4	7.3	6.1	6.9	7.3	7.5	6.6
Blue Cross-Blue Shield	3.7	14.6	24.9	42.1	39.4	39.3	43.3	45.0	[12] 48.4
Other plans	(NA)	(NA)	(NA)	(NA)	12.4	[12] 13.7	[12] 15.1	[12] 25.7	[12] 33.7
In-hospital medical visits:									
Estimate by HCFA (net) [10]	(NA)	(NA)	145.6	151.6	160.2	163.5	167.6	(NA)	(NA)
Percent of population covered [4]	(NA)	(NA)	71.5	70.5	73.0	73.7	74.7	(NA)	(NA)
Estimate by HIAA (net) [6]	83.2	109.6	138.7	161.9	160.4	[7] 165.0	[7] 164.8	[7] 169.5	[7] 163.9
Percent of population covered [4]	46.3	56.8	68.1	75.3	73.1	74.4	73.5	74.7	71.6
X-ray and lab. exams (out-of-hospital) (net) [10]	(NA)	79.5	142.4	158.7	148.2	151.1	166.4	(NA)	(NA)
Percent of population covered [4]	(NA)	41.2	70.0	72.9	66.6	68.1	74.2	(NA)	(NA)
Office and home visits (net) [10]	(NA)	(NA)	87.8	127.7	124.3	135.8	133.4	(NA)	(NA)
Percent of population covered [4]	(NA)	(NA)	33.3	59.4	56.7	61.2	59.5	(NA)	(NA)
Dental care (net) [10]	(NA)	3.1	12.0	30.0	44.4	53.8	60.3	(NA)	(NA)
Percent of population covered [4]	(NA)	1.6	5.9	14.0	20.2	24.3	26.9	(NA)	(NA)
Prescribed drugs (out-of-hospital) (net) [10]	(NA)	53.2	101.0	149.3	131.4	132.3	131.2	(NA)	(NA)
Percent of population covered [4]	(NA)	27.6	49.6	69.5	59.9	59.7	58.5	(NA)	(NA)
Private duty nursing (net) [10]	(NA)	56.0	100.2	145.9	129.9	133.7	126.9	(NA)	(NA)
Percent of population covered [4]	(NA)	29.0	49.2	67.9	59.2	60.3	56.6	(NA)	(NA)
Visiting nurse service (net) [10]	(NA)	60.1	106.9	141.6	130.3	140.0	161.1	(NA)	(NA)
Percent of population covered [4]	(NA)	31.2	52.5	65.9	59.4	63.1	71.8	(NA)	(NA)
Nursing home care (net) [10]	(NA)	9.9	32.4	70.1	81.1	84.5	97.6	(NA)	(NA)
Percent of population covered [4]	(NA)	5.1	15.9	32.6	27.9	38.1	43.5	(NA)	(NA)

NA Not available. [1] Surveys by U.S. National Center for Health Statistics. [2] 1962 data. [3] 1967 data. [4] Based on Bureau of the Census estimated civilian population as of January 1 of following year. [5] Includes duplication which occurs when persons are members of an independent prepaid or self-insured plan or other health plan with which an insurance company has an administrative service agreement and/or a minimum premium plan. [6] Beginning 1975, includes Puerto Rico and outlying areas. [7] Source: Health Insurance Association of America, Washington, D.C., *Source Book of Health Insurance Data*, annual. [8] Beginning 1977, excludes persons covered in administrative service only and minimum premium plans. [9] All private plans other than Blue Cross-Blue Shield and insurance companies. [10] Estimates by Health Care Financing Administration (HCFA). [11] Coverage provides protection against especially heavy medical bills resulting from "catastrophic" or prolonged illness, and is used to supplement basic medical care insurance or as a comprehensive integrated program providing both basic and major medical protection, including charges for private duty nursing, drugs, and medical appliances. [12] Estimated.

Source: Except as noted, U.S. Health Care Financing Administration, *Health Care Financing Review*, Fall 1981. Data for 1960-1975 published by U.S. Social Security Administration in *Social Security Bulletin*, September 1978, and earlier issues.

MEDICAL MALPRACTICE

STATE-BY-STATE ANALYSIS (as of 12/02/83)

Introductory Note

1. The scope of the analysis is limited, with the exception of the statutes of limitation, to special medical malpractice statutes. In other words, if there is nothing beside a certain category title, the reader may conclude that the legislature has not enacted a statute in that area which deals exclusively with medical malpractice cases. The reader may not conclude from such absence of notation, however, that there is no general legislation on that topic. For example, it is not correct to conclude that Alabama has no legislation regarding the admissibility of evidence of collateral sources, only that that state has no medical malpractice statute on that subject.

2. Notwithstanding the occasional mention of certain cases which rule on the constitutionality of selected statutes, the analysis is in no way a comprehensive listing of every state case which has ruled on the constitutionality of a state medical malpractice statute.

3. The analysis does not attempt to describe in detail the provisions of the statutes mentioned; rather, it discusses only the general features of those statutes. The analysis has, however, provided citations to the statutes so that more detailed analysis may be conducted by the reader if desired.

4. With respect to the category "Collateral Source Rule", the analysis refers only to collateral sources of benefits to the plaintiff, not the defendant.

5. Under the category "Ad Damnum Clause", the analysis discusses the permissibility of a request in the Complaint for a specific amount of damages sought by the plaintiff. Where the comment is "Eliminated", or "Prohibited", therefore, the plaintiff may not specify a certain amount of damages sought in the suit. However, most states which have prohibited such clauses do permit a statement which allows the plaintiff to certify that the amount sought is in excess of any minimum amounts which serve as a jurisdictional requirement.

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AL	Panels and Arbitration	Voluntary binding arbitration allowed. (Code of Alabama 6-5-485)
	Statute of Limitation/Repose	2 years from act, except if cause of action is not discovered or reasonably discoverable in 2 years, in which case 6 months after discovery or reasonable discoverability; in no event more than 4 years after act. Minor under 4 years must commence action by 8th birthday if statute would have otherwise expired. (6-5-482)
	Limitation on Recoveries and Fees	Court may order periodic payments if award over $100,000, but payments do not end at death. (6-5-486)
	Collateral Source Rule	
	Standard of Care	"Same general neighborhood and same general line of practice." (6-5-484)
	Ad Damnum Clause	Eliminated. (6-5-483)
		Constitutionality of above provisions upheld in Thomas v. Niemann, 397 So.2d 90 (Ala. 1981).
AK	Panels and Arbitration	Expert advisory panel may be appointed by court to help the court screen the case. Findings are admissible in trial. (09.55.536) Voluntary binding arbitration allowed; panel available to arbitrators.
	Statute of Limitation/Repose	2 years from date cause of action arises. (09.10.070) Tolled by disability.
	Limitation on Recoveries and Fees	Court may order periodic payments for future damages. (09.55.548)
	Collateral Source Rule	Modified with few exceptions, plaintiff can recover only damages in excess of collateral sources, but evidence admissible only after

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		fact-finder awards a judgment. (09.55.548(b))
	Standard of Care	Speciality rule. (09.55.548)
	Ad Damnum Clause	Eliminated (9.55.547).
AZ	Panels and Arbitration	Review panel whose finding is non-binding but admissible at trial. (ARS 12-567). Panel may be waived if both parties agree or if damages are agreed to be less than $50,000. Constitutionality upheld, Eastin v. Broomfield, 116 Ariz 576, 570 P.2d 744 (1977).
	Statute of Limitation/Repose	3 years from injury; if foreign object or intentional fraud, from time of discovery or reasonable discoverability. Minor statute tolls until 7th birthday (12-564).
	Limitation on Recoveries and Fees	Reasonableness of attorneys fees subject to review (12-568).
	Collateral Source Rule	Modified evidence of collateral sources and plaintiff's contributions thereto are admissible; no subrogation allowed. (12-565).
	Standard of Care	State-wide (12-563).
	Ad Damnum Clause	Eliminated (12-566).
AR	Panels and Arbitration	Claim may be brought by plaintiff before voluntary hearing panel; decision binding only if parties so agree. (ASA 34-2603-2607). 60-day notice of intent to sue required. (34-2617).
	Statute of Limitation/Repose	2 years from act; if foreign object, suit must be within 1 year of discovery or reasonable discoverability. Minor: action must be commenced by 19th birthday. Incompetent has 1 year from removal of disability. (34-2616).

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	Limitation on Recoveries and Fees	Court may order periodic payments of future damages over $100,000; upon plaintiff's death, no payment of future pain and suffering and costs of care. (34-2619).
	Collateral Source Rule	
	Standard of Care	Locality or similar locality and same type of practice or specialty. (34-2614).
	Ad Damnum Clause	Eliminated (34-2618).
CA	Panels and Arbitration	Arbitration clauses provided for in contracts for medical services (Deering's CCCP 1295). "Certificate of Merit" required to be filed by plaintiff's attorney after consultation with doctor. (CCCP 411.30).
	Statute of Limitations/Repose	3 years after injury or 1 year after discovery or reasonable discoverability, whichever occurs first; in no event more than 3 years after injury, unless intentional concealment, fraud, or a foreign object . Minor under six: action must be commenced within 3 years or before 8th birthday, whichever provides a longer period. (CCCP 340.5). 90-day notice requirement. (CCCP 364).
	Limitation on Recoveries and Fees	$250,000 limit on non-economic damages (Civil Code 3333.2). Constitutionality upheld, Fein v. Permanente Medical Group, 121 Cal. App. 3d 135, 175 Cal. Rptr. 177 (1981), hrg. granted by Supreme Court. Requirement of periodic payments of future damages over $50,000 (with remaining payments to plaintiff's family on his/her death) (CCCP 667.7) held unconstitutional, American Bank and Trust Co. v. Community Hosp., 190 Cal. Rptr. 371, 660 P.2d 829 (1983).

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		Attorneys fees limited. (Bus. & Prof. Code 6146).
	Collateral Source Rule	Modified evidence permitted, but subrogation precluded. (Civil Code 3333.1)
	Standard of Care	
	Ad Damnum Clause	
CO	Panels and Arbitration	
	Statute of Limitations/Repose	2 years after discovery or reasonable discoverability. In no event more than 3 years after act, except if knowing concealment or foreign object, in which event 2 years after discovery or reasonable discoverability. Minor under 6 has until 8th birthday to file. (Col. Stats. 13-80-105). Constitutionality upheld against an equal protection attack in Mishek v. Stanton, 616 P. 2d 135 (Colorado 1980).
	Limitation on Recoveries and Fees	
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	Eliminated (13-21-112).
CT	Panels and Arbitration	Non-binding voluntary panel available if all parties agree. Findings admissible. (Conn. Stat. 38-19b f).
	Statute of Limitations/Repose	2 years from injury or discovery or reasonable discoverability, but no more than 3 years after the date of the act. If concealment, from discovery. (52-584).
	Limitation on Recoveries and Fees	
	Collateral Source Rule	

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	Standard of Care	
	Ad Damnum Clause	
DE	Panels and Arbitration	Any party may convene a screening panel. (DCA 18-6802 18-6814). Expert testimony required unless panel finds negligence, foreignobject, explosion, fire, or wrong part of body (18-6853).
	Statute of Limitations/Repose	2 years from injury; if not discoverable, 3 years from injury. Minor: either adult standard, or by 6th birthday. (18-6856).
	Limitation on Recoveries and Fees	Court may award periodic payments of future damages (reduced in the event of certain contingencies); if plaintiff dies, payments for future damages end, remainder to survivors. (18-6864). Limit on attorneys fees (18-6865). Limit on punitive damages (18-6855).
	Collateral Source Rule	Modified evidence of public collateral sources is admissible. (18-6862).
	Standard of Care	Locality rule, although any Delaware doctor who has been in active practice may give expert testimony as to the applicable standard of care. (18-6854).
	Ad Damnum Clause	Constitutionality upheld, DiFilippo v. Beck, 520 F. Supp. 1009 (D. Del. 1981); Lacy v. Green, 428 A.2d 1171 (Del. Super. 1981).
DC	Panels and Arbitration	
	Statute of Limitations/Repose	3 years if based upon negligence, 1 year if based upon battery. (DCS 12-301).

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	Limitation on Recoveries and Fees	
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	
FL	Panels and Arbitration	Mandatory panel, conclusions (but not findings) admissible. (FSA 768.44 & 768.47). Constitutionality upheld, Carter v. Sparkman, 335 So.2d 802 (Fla. 1976).
	Statute of Limitations/Repose	2 years from act or from discovery or discoverability, but no later than 4 years from act. If fraud, concealment, or intentional misrepresentation prevented discovery within 4-year period, 2 years from discovery or reasonable discoverability, but no more than 7 years after act. (95.11).
	Limitation on Recoveries and Fees	Limits: $150,000 per claim (escalates by $50,000 each July 1st), $500,000 per occurrence, the excess paid by Patient Compensation Fund up to whatever limit between $1 and $10 million is selected by the Health Care Provider. (768.54). Held unconstitutional, Florida Medical Center v. Von Stetina, ___ So.2d ___ (Fla. 4th DCA August 10, 1983)). Court reviews verdict (768.49). Court may order periodic payments of future damages (some ending at death of plaintiff). (768.51). Held unconstitutional, Florida Medical Center, supra). Court awards attorneys fees to prevailing party, which fees must be reasonable (768.56). Constitutionality upheld, id.
	Collateral Source Rule	Once award is made, the court shall reduce the award by the amount of

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		payments by collateral sources, unless the right of subrogation exists for those sources. (768.50). Constitutionality upheld, Pinillos v. Cedars of Lebanon Hospital Corp., 403 So.2d 365 (Fla. 1981).
	Standard of Care	Same or similar medical community; specialist rule (768.45).
	Ad Damnum Clause	Previously, "Florida Medical Liability Mediation Act" held unconstitutional, Aldana v. Holub, 381 So.2d 231 (1980).
GA	Panels and Arbitration	
	Statute of Limitations/Repose	2 years from act; if foreign object, 1 year after discovery. Disabilities toll the statute until removal. (Code 9-3-71, 9-3-72).
	~~Limitation on Recoveries and Fees~~	
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	
HI	Panels and Arbitration	Mandatory panel findings neither binding nor admissible. (HRS Sect. 671-11 through 671-19).
	Statute of Limitations/Repose	2 years from discovery or reasonable discoverability, but no more than 6 years after act. Statute is tolled for any period during which the person has failed to disclose any act, error, or omission upon which the action is based and which is known or reasonably knowable (657-7.3).

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	Limitation on Recoveries and Fees	Attorneys fees must be reasonable (671-2). Patient Compensation Fund pays damages in excess of defendant's mandatory insurance (limits established by the insurance commissioner up to $1 million/$5 million). (671-32, 671-36). Fund also pays claims after the 6-year statute of limitations' outside limit.
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	Prohibited (671-4).
ID	Panels and Arbitration	Compulsory but non-binding hearing before a screening panel, with the results not usable in any way on trial. (IC 6-1001 6-1011).
	Statute of Limitations/Repose	If based on wrongful act, neglect, breach of implied or express warranty, 2 years from act. If for- eign object or fraudulent concealment, 1 year from discovery or reasonable discoverability or 2 years from act, whichever is later. (5-219). Constitutionality upheld, Holmes v. Iwasa, ___Id.___, 657 P.2d 476 (1983).
	Limitation on Recoveries and Fees	Physician liability limit: $150,000 per patient, $300,000 aggregate. (39-4204). Hospital liability limit: $150,000 per patient, $300,000 aggregate, or number of beds times $10,000 (whichever is greater). (39-4205). Actions limited to common law negligence. (39-4203). Provisions held unconstitutional, Jones v State Board of Medicine, Nos. 55527 and 55586 (Idaho D.C., 4th Dist., November 14, 1980), on remand from 97 Idaho 859, 555 P.2d 399 (1976). Both physician and hospital must have insurance (39-4206). Attorneys fees limited to 40% (39-4213).

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	Collateral Source Rule	Virtually abolished. (39-4210). Abolition held unconstitutional, Jones, supra.
	Standard of Care	Community and speciality rules. (6-1013).
	Ad Damnum Clause	
IL	Panels and Arbitration	Medical Malpractice Pre-trial Review Panel held unconstitutional, Wright v. Central Du Page Hospital Assoc., 63 Ill.2d 313, 347 N.E.2d 736 (1976). Panel was binding, if parties so agreed. Otherwise, an express rejection of a unanimous determination was required before a case could proceed to trial. "Health Care Arbitration Act", IAS Ch. 10, paras. 201-214, governs all arbitration agreements in the field.
	Statute of Limitations/Repose	2 years from discovery or reasonable discoverability, but in no event more than 4 years from act. Statute tolls for the duration of disabilities such as minority (under age 18), insanity, imprisonment, and mental illness (Ill. Stat. Ch. 83, Sect. 22.1). Constitutionality upheld, Anderson v. Wagner, 79 Ill.2d 295, 402 N.E.2d 560, app. dismd 449 U.S. 807 (1979).
	Limitation on Recoveries and Fees	Limit of $500,000 on recoveries held unconstitutional, Wright, supra at 742-43 (1976). Patients' Compensation Fund (Ch. 73, paras. 1065.300 - 1065.315): activated if medical malpractice insurance is not available to provide excess coverage over $100,000. Purpose is to pay amount of award over $100,000 up to $500,000.
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	

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IN	Panels and Arbitration	Mandatory panel, conclusions admissible. (Ind. Stat. 16-9.5-9-2). Constitutionality upheld, Johnson v. St. Vincent Hospital, 404 N.E.2d 585 (Ind. 1980).
	Statute of Limitations/Repose	2 years from act. Minor under 6 years old: statute tolls until 8th birthday. (16-9.5-3-1). Constitutionality upheld, Rohrabaugh v. Wagoner, 413 N.E. 2d 891 (Ind. 1980).
	Limitation on Recoveries and Fees	$100,000 per practitioner per incident with a $300,000 annual aggregate; additional recovery up to $500,000 from a state fund. (16-9.5-2-2). Constitutionality upheld, Johnson, supra. Attorneys fees limited to no more than 15% of any recovery from the state fund. (16-9.5-5-1).
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	Prohibited. (16-9.5-1-6).
IA	Panels and Arbitration	
	Statute of Limitations/Repose	2 years from discovery or reasonable discoverability, but in no event more than 6 years after act unless a foreign object was unintentionally left in the body. (Iowa Code 614.1 Sub 9).
	Limitation on Recoveries and Fees	Attorneys fees subject to review for reasonableness (147.138).
	Collateral Source Rule	Virtually abolished no recovery to the extent collateral sources provide benefits. (147.136). Constitutionality upheld, Rudolf v. Iowa Methodist Medical Center, 293 N.W.2d 550 (Iowa 1980).

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	Standard of Care	
	Ad Damnum Clause	Prohibited. (619.18).
KS	Panels and Arbitration	Judge or one party may request panel; findings not admissible. (Kan. Stat. 65-4901 - 65-4908).
	Statute of Limitations/Repose	2 years from act, "unless the fact of injury is not reasonably ascertainable until some time after the initial act, then the period of limitation shall not commence until the fact of injury becomes reasonably ascertainable to the injured party, but in no event shall such an action be commenced more than 10 years beyond" the act, if not based in contract, or 4 years if based in contract. (60-513). Constitutionality upheld, Stephens v. Snyder Clinic Association, 230 Kan. 115, 631 P.2d 222 (1981).
	Limitation on Recoveries and Fees	Court may require payment of judgment in periodic payments. (60-2609). Attorneys fees subject to court's review for reasonableness. (7-121 b).
	Collateral Source Rule	Modified. (60-471).
	Standard of Care	
	Ad Damnum Clause	
KY	Panels and Arbitration	
	Statute of Limitations/Repose	1 year from discovery or reasonable discoverability, but no more than 5 years after act. (KRS 413.140).
	Limitation on Recoveries and Fees	Patients Compensation Fund (304.40-330) provided to pay claims in excess of $100,000, with no upper limit.

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	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	Prohibition (304.40-270) held unconstitutional, McCoy v. Western Baptist Hospital, 628 So.2d 634 (1981).
LA	Panels and Arbitration	Mandatory panel conclusions admissible. (La. Stat. 40:1299.47). Constitutionality upheld, Everett v. Goldman, 359 So.2d 1256 (La. 1978); Butler v. Flint-Goodridge Hospital of Dillard University, 354 So.2d 1070 (La. App. 1978); Seoane v. Ortho Pharmaceuticals Inc., 660 F.2d 146 (5th Cir. 1981).
	Statute of Limitations/Repose	1 year from act or date of discovery, but in no event more than 3 years from date of act. (5628).
	Limitation on Recoveries and Fees	Awards limited to $100,000 per health care provider, $500,000 overall limitation of liability. Excess over $100,000 paid by patient compensation fund. (40:1299.42). Limitation of liability for state services. (40:1299.39B).
	Collateral Source Rule	
	Standard of Care	Community and speciality rules. (40:1299.41(7)).
	Ad Damnum Clause	
ME	Panels and Arbitration	One party may request panel findings inadmissible. (MRS 24-2801 - 24-2809).
	Statute of Limitations/Repose	2 years after cause of action accrues (14-753).
	Limitation on Recoveries and Fees	90 days notice required (24-2903).

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	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	Prohibited (24-2901).
MD	Panels and Arbitration	Mandatory non-binding arbitration panel; finding admissible and the burden is on the party rejecting the panel's award. (ACM, Cts. & Jud. Proc. 3-2A-03 - 3-2A-06). Constitutionality upheld, Attorney General v. Johnson, 282 Md. 274, 385 A.2d 57, appeal dismissed, 439 U.S. 805 (1978).
	Statute of Limitations/Repose	5 years from act or 3 years from discovery, whichever is shorter. If plaintiff is under 16 at time of act, statute tolls until 16th birthday (Cts. & Jud. Proc. 2-5-109).
	Limitation on Recoveries and Fees	Court or panel may award periodic payments. (Cts. & Jud. Proc. 3-2A-08). Attorneys fees subject to review of panel or court. (Cts. & Jud. Proc. 3-2A-07).
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	Prohibited (3-2A-02).
MA	Panels and Arbitration	Mandatory tribunal (Anno. Laws of Mass., Ch. 231, Sect. 60B). Constitutionality upheld, Paro v. Longwood Hospital, 373 Mass. 645, 369 N.E.2d 985 (1977).
	Statute of Limitations/Repose	Minors: 3 years from accrual of cause of action; if under 6 years old, statute tolls until 9th birthday (60D).
	Limitation on Recoveries and Fees	$2,000 bond required after adverse finding by tribunal. (60B).

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	Collateral Source Rule	
	Standard of Care	Community and speciality rules. (600.2912 a).
	Ad Damnum Clause	Prohibited (60C).
MI	Panels and Arbitration	Arbitration agreement must be offered to patient. (MCLA 500.3053 et seq.).
	Statute of Limitations/Repose	2 years from accrual (time that plaintiff discontinues treatment with Doctor on subject of suit, regardless of discovery). Additionally, 6 months from discovery or reasonable discoverability (600.5838 and 600.5805(4). Person under disability has 1 year after removal of disability. (600.5851).
	Limitation on Recoveries and Fees	
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	
MN	Panels and Arbitration	
	Statute of Limitations/Repose	Within 2 years of act (MSA, Vol 32, Sect. 541.07).
	Limitation on Recoveries and Fees	
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	
MS	Panels and Arbitration	
	Statute of Limitations/Repose	2 years after discovery or reasonable discoverability. Minor/ unsound mind: 2 years after minority/disability ceases (MCA 15-1-36).

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	Limitation on Recoveries and Fees	
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	
MO	Panels and Arbitration	Mandatory review board; findings inadmissible. (RSM 538.010 et seq.).
	Statute of Limitations/Repose	2 years from act; if foreign object, 2 years from discovery. Minor under 10 years old has until 12th birthday to file. In no event more than 10 years from act. (516.105). Constitutionality upheld, Ross v. Kansas City General Hospital & Medical Center, 608 S.W.2d 397 (Mo. 1980).
	Limitation on Recoveries and Fees	
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	
MT	Panels and Arbitration	Mandatory panel; non-binding and not admissible. (RCMA 27-6-101 et seq.). Constitutionality upheld, Linder v. Smith, 629 P.2d 1187 (Mont. 1981).
	Statute of Limitations/Repose	3 years from act or discovery or reasonable discoverability, whichever occurs last, but in no event more than 5 years after act. Statute tolls during period of failure of disclosure of act (27-2-205).
	Limitation on Recoveries and Fees	
	Collateral Source Rule	

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	Standard of Care	
	Ad Damnum Clause	
NE	Panels and Arbitration	Mandatory panel; findings admissible but not binding. (RSN 44-2840). Constitutionality upheld, Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977).
	Statute of Limitations/Repose	2 years from act, 1 year after discovery, but no more than 10 years after date of services which is basis for the cause of action (44-2828).
	Limitation on Recoveries and Fees	Liability limited to $100,000 for health care provider, with excess up to $500,000 paid by Excess Liability Fund (44-2825; 44-2829). Constitutionality upheld, Prendergast, supra. Attorneys fees subject to review for reasonableness (44-2834).
	Collateral Source Rule	Modified evidence of collateral sources inadmissible, but taken as credit against judgment. (44-2819).
	Standard of Care	Locality or similar locality; speciality rule. (44-2810).
	Ad Damnum Clause	Prohibited (44-2822).
NV	Panels and Arbitration	Mandatory panel (NRS 41A.040). Repealed 1981 Laws 327.
	Statute of Limitations/Repose	4 years after injury or 2 years after discovery, whichever occurs first. If concealed, statute tolls. Minor: statute tolls until age of 10 for brain damage or birth defect; if sterility, 2 years after discovery (41A.097).
	Limitation on Recoveries and Fees	
	Collateral Source Rule	

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	Standard of Care	Community rule. (630.013). Expert testimony required with certain exceptions (41A.100).
	Ad Damnum Clause	
NH	Panels and Arbitration	
	Statute of Limitations/Repose	2 years from act. If foreign object, 2 years from discovery or reasonable discoverability. Minor under 8 has until age 10 to file. 60-day advance notice requirement. (RSA 507-C). Entire special medical malpractice statute of limitations provision declared unconstitutional, Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980), because it (1) limited discovery rule to foreign object cases, (2) extinguished rights under RSA 508:8: "An infant or mentally incompetent person may bring a personal action within two years after such disability is removed," and (3) burdened malpractice plaintiffs, and no others, with 60-day notice requirement.
	Limitation on Recoveries and Fees	$250,000 limit on awards for non-economic loss (507-C:7 II). Held unconstitutional, Carson, supra at 838. Any future damages in excess of $50,000 must be paid in periodic payments which would cease upon plaintiff's death (507-C:7 IV). Held unconstitutional, Carson, supra at 838. Attorneys fees limited to contingent fees set in statutory scale (507-C:8). Held unconstitutional, Carson, supra at 839.
	Collateral Source Rule	Defendant may introduce evidence of compensation from collateral sources, and jury is instructed to reduce award by amount of such compensation, less amounts paid by

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		plaintiff to secure such compensation (507-C:7 I). Held unconstitutional, Carson, supra at 836.
	Standard of Care	Expert witness must have been "competent and duly qualified to render or supervise equivalent care to that which is alleged to have caused the injury, at the time that such care was rendered." (507-C3). Held unconstitutional, Carson, supra at 832.
	Ad Damnum Clause	
NJ	Panels and Arbitration	
	Statute of Limitations/Repose	2 years after accrual (NJRS 2A:14-2).
	Limitation on Recoveries and Fees	
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	
NM	Panels and Arbitration	Mandatory medical review commission; report inadmissible. (NMS 41-5-15).
	Statute of Limitations/Repose	3 years from date of malpractice. Minor under 6 has until 9th birthday to file. (41-5-13).
	Limitation on Recoveries and Fees	"Except for punitive damages and medical care and related benefits," a limit of $500,000 per incident. If jury returns a verdict of greater than $500,000 and finds that the value of "accrued medical care and related benefits equals or exceeds the amount by which the jury award exceeds $500,000," the court shall enter judgment in the amount of the award. If accrued medical care and related benefits are less than the

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		excess over $500,000, the court shall reduce the award by the amount of the difference between the two figures. If the plaintiff foregoes a jury trial, the value of such accrued care and benefits are not subject to the $500,000 limitation. Health care provider is personally liable up to $100,000; excess is paid out of the patient compensation fund. (41-5-6). Although no monetary damages are awarded for future medical expenses, the health care provider/ defendant is personally liable for the provision of such care as long as needed, subject to the above personal liability limit of $100,000. Again, excess is paid by fund. (41-5-7).
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	Prohibited (41-5-4).
NY	Panels and Arbitration	Medical malpractice panel (If unanimous, recommendation admissible as evidence (Cons. Laws of NY, Jud. 148-a). Constitutionality upheld, Comiskey v. Arlen, 55 App. Div. 2d 304, 390 N.Y.S.2d 122, Aff'd 43 N.Y.2d 696, 401 N.Y.S.2d 200, 372 N.E.2d 34 (1976).
	Statute of Limitations/Repose	2 years, 6 months from act; continuous treatment rule. If foreign object, 1 year from discovery. (CPCR 214-a).
	Limitation on Recoveries and Fees	Attorneys fees limited by schedule. (Jud. 474-a).
	Collateral Source Rule	Modified Court shall set off collateral sources against award, with credit for premiums paid. (CPCR 4010).

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STATE-BY-STATE ANALYSIS: MEDICAL MALPRACTICE
(12/2/83)

	Standard of Care	
	Ad Damnum Clause	Prohibited (CPLR 3017(c)).
NC	Panels and Arbitration	
	Statute of Limitations/Repose	Within 3 years of act or 1 year from discovery or reasonable discoverability, but no more than 10 years from act. (GSNC 1-15).
	Limitation on Recoveries and Fees	
	Collateral Source Rule	
	Standard of Care	Same or similar community (90-21.12).
	Ad Damnum Clause	"
ND	Panels and Arbitration	Review panel (NDCC 32-29.1). Repealed, SL 1981, ch. 358, sect. 1.
	Statute of Limitations/Repose	2 years from discovery, but no more than 6 years after act, unless discovery prevented by fraudulent conduct of defendant. (28-01-18).
	Limitation on Recoveries and Fees	$300,000 limit for awards for all claims arising out of one occurence (26-40.1-11). Patient trust fund may, in the court's discretion, be used to provide periodic payments if award exceeds $100,000 (26-40.1-15, 16, 17). If insurer pays $100,000 limit, excess suit is without jury (26-40.1-17). All such limits held unconstitutional, Arneson v. Olson, 270 N.W. 2d 125, 135 (N.D. 1978).
	Collateral Source Rule	Abolition (26-40.1-08) held unconstitutional, Arneson, supra at 137.
	Standard of Care	
	Ad Damnum Clause	

STATE-BY-STATE ANALYSIS: MEDICAL MALPRACTICE
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OH	Panels and Arbitration	Mandatory lay arbitration board (opinion admissible) (Ohio Code 2711.21). Constitutionality upheld, Beatty v. Akron City Hospital, 67 Ohio St. 2d 483, 21 Ohio Ops. 3d 302, 424 N.E.2d 586 (1981). Arbitration agreement form, with patient's right to cancel (2711.24).
	Statute of Limitations/Repose	1 year from accrual; no more than 4 years after act. Minor under 10 has until 14th birthday to file. (2305.11).
	Limitation on Recoveries and Fees	$200,000 limitation on general damages in non-death cases (2307.43). Ruled unconstitutional, Simon v. St. Elizabeth Medical Center, 355 N.E.2d 903, 908 (Ct. of Common Pleas 1976); Graley v. Satyatham, 74 Ohio Ops. 2d 316, 343 N.E.2d 832 (Ct. of Common Pleas 1976).
	Collateral Source Rule	Modified (2305.27). Held unconstitutional, Graley, supra.
	Standard of Care	
	Ad Damnum Clause	Prohibited (2307.42). Held unconstitutional, Simon, supra at 906; Graley, supra.
OK	Panels and Arbitration	
	Statute of Limitations/Repose	2 years of discovery or reasonable discoverability, provided that any action brought more than 3 years from date of injury shall be limited to actual medical and surgical expenses incurred as a direct result of injury. Minority or incompetency tolls the statute. (Stat. Ch. 76, Sect. 18).
	Limitation on Recoveries and Fees	
	Collateral Source Rule	

STATE-BY-STATE ANALYSIS: MEDICAL MALPRACTICE
(12/2/83)

	Standard of Care	
	Ad Damnum Clause	
OR	Panels and Arbitration	
	Statute of Limitations/Repose	2 years from discovery or reasonable discoverability, but no more than 5 years from act, unless fraud (ORS 12.110; 752.040).
	Limitation on Recoveries and Fees	Physician's liability limited to amount of insurance $100,000 per claim & $300,000 per occurrence. (752.040). Excess paid by Insurance Commissioner (752.060). Attorneys fees limited to 33-1/3% (752.150).
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	
PA	Panels and Arbitration	As originally passed, arbitration panel had original, exclusive jurisdiction over all medical malpractice cases. (Penn. CSA 1301.308, 1301.309). Such jurisdiction was held unconstitutional, Mattos v. Thompson, 491 Pa. 385, 421 A.2d 190 (1980). In light of Mattos, all parties must agree to arbitration. The rest of the arbitration system's constitutionality has been upheld, Parker v. Childrens' Hospital of Philadelphia, 483 Pa. 106, 394 A.2d 932 (1978). Panel decision is admissible (1301.510).
	Statute of Limitations/Repose	2 years from accrual. If claim is made more than 4 years after tort occurred but is filed within statute of limitations period, Medical Professional Liability Catastrophic

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		Loss Fund will defend and pay (1301.605). Mandatory insurance (1301.701).
	Limitation on Recoveries and Fees	Attorneys fees limited (1301.604). Held unconstitutional, 1985. Punitive damages allowed (1301.603).
	Collateral Source Rule	Modified - award shall be reduced by the amount of all collateral benefits; subrogation prohibited. (1301.602).
	Standard of Care	
	Ad Damnum Clause	
RI	Panels and Arbitration	Superior Court justice presides at preliminary hearing within 90 days of defendant's answer. If justice concludes that injury is "merely an unfortunate medical result," the justice shall dismiss the action with prejudice (GL 10-19-2 through 10-19-5). Held unconstitutional, Boucher v. Sayeed, 459 A.2d 87 (R.I. 1983).
	Statute of Limitations/Repose	3 years from act. If minor, mental incompetence, etc, 1 year from removal of disability. If not discoverable within the statute of limitations, 1 year from discovery or discoverability. (9-1-14.1).
	Limitation on Recoveries and Fees	
	Collateral Source Rule	Modified - evidence of collateral sources is admissible in trial. (9-19-34).
	Standard of Care	
	Ad Damnum Clause	Prohibited. (9-1-30).
SC	Panels and Arbitration	
	Statute of Limitations/Repose	3 years from discovery or reason-

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		able discoverability, but no more than 6 years from act. Foreign object - 2 years from discovery (SCC 15-3-545).
	Limitation on Recoveries and Fees	Physician liability limited to $100,000 per claim, $300,000 per year; Patient Compensation Fund pays excess. (38-59-120).
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	
SD	Panels and Arbitration	
	Statute of Limitations/Repose	2 years from act (SDC 15-2-14.1).
	Limitation on Recoveries and Fees	$500,000 overall limit on general damages only. (21-3-11).
	Collateral Source Rule	Modified - evidence of collateral sources not subject to subrogation and not purchased privately by the plaintiff is admissible. (21-3-12).
	Standard of Care	
	Ad Damnum Clause	
TN	Panels and Arbitration	Mandatory review board (waivable if all parties agree). (29-26-104). Board decision admissible (29-26-112).
	Statute of Limitations/Repose	1 year from discovery, but no more than 3 years from act unless fraud or foreign object. (29-26-116). Constitutionality upheld, Harrison v. Schrader, 569 S.W.2d 822 (Tenn. 1982).
	Limitation on Recoveries and Fees	Attorneys fees limited to 33-1/3% (29-26-120).

STATE-BY-STATE ANALYSIS: MEDICAL MALPRACTICE
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	Collateral Source Rule	Modified - plaintiff may not recover for amount covered by collateral sources unless purchased privately and individually. (29-26-119).
	Standard of Care	Same or similar community and specialty rule. (29-26-115).
	Ad Damnum Clause	May be pleaded, but not disclosed to jury (29-26-117).
TX	Panels and Arbitration	
	Statute of Limitations/Repose	2 years from occurrence. Minor under 12 has until 14th birthday to file (Vernon's TSA, art. 4590i, Sect. 10.01).
	Limitation on Recoveries and Fees	Liability limit of $500,000 on all non-medical-expense damages (11.02). Alternate limitation on recovery in case 11.02 is stricken (11.03). 60 days notice required (4.01).
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	Prohibited (5.01).
UT	Panels and Arbitration -	
	Statute of Limitations/Repose	2 years from discovery or discoverability, but no more than 4 years from act. If foreign object or fraud, 1 year from discovery (UCA 78-14-4).
	Limitation on Recoveries and Fees	90 day notice of intent to sue (78-14-8).
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	Prohibited (78-14-7).

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VT	Panels and Arbitration	Voluntary arbitration (7002).
	Statute of Limitations/Repose	3 years from act or 2 years from discovery or discoverability, but no more than 7 years from act. If fraud, no statute of limitations shall bar claim. If foreign object, 2 years from discovery. (Stat. tit. 12, Sect. 521).
	Limitation on Recoveries and Fees	
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	
VA	Panels and Arbitration	Optional panel (Code 8.01-581.2). Panel opinion admissible (8.01-581.8). Binding arbitration is permissible (8.01-581.12).
	Statute of Limitations/Repose	2 years from accrual. If infant, within 5 years of accrual. (8.01-243).
	Limitation on Recoveries and Fees	$1,000,000 overall limit. (8.01-581.15). 60 days notice required (8.01-581.2).
	Collateral Source Rule	
	Standard of Care	State-wide, unless party shows that similar locality rule is more appropriate (8.01-581.20).
	Ad Damnum Clause	
WA	Panels and Arbitration	
	Statute of Limitations/Repose	3 years from act or 1 year from discovery or reasonable discoverability, but no more than 8 years after act. If legal disability, statute does not apply. (4.16.350).

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	Limitation on Recoveries and Fees	Court reviews attorneys fees. (7.70.070). Court may order periodic payments. (4.56.240).
	Collateral Source Rule	Modified - evidence of all collateral sources is admissible except privately obtained insurance. (7.70.080).
	Standard of Care	State-wide (7.70.040).
	Ad Damnum Clause	Prohibited (4.28.360).
WV	Panels and Arbitration	
	Statute of Limitations/Repose	2 years after accrual, 1 year for wrongful death (discovery rule applied by courts). (WVS 55-2-12).
	Limitation on Recoveries and Fees	
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	
WI	Panels and Arbitration	Mandatory panels. (RSW 655.02 - 655.04). Parties can stipulate that panel findings will be binding. (655.07). Formal panel opinion admissible; informal panel opinion not admissible. (655.19). Constitutionality upheld, State ex rel. Strykowski v. Wilkie, 81 Wis. 2d 491, 261 N.W.2d 434 (1978).
	Statute of Limitations/Repose	3 years from injury or 1 year from discovery or discoverability, but no more than 5 years from act. If concealment or foreign object, 1 year from discovery or reasonable discoverability. (893.55).
	Limitation on Recoveries and Fees	$200,000 per practitioner per incident (or maximum amount for which insured, whichever is higher), $600,000 annual aggregate; un-

STATE-BY-STATE ANALYSIS: MEDICAL MALPRACTICE
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		limited recovery from state fund (655.23; 655.27). If fund falls below $2.5 million, $500,000 limitation on damages. (id). Future medical payments over $25.000 paid into Patient Compensation Fund & disbursed until patient dies (655.015). Limitations on attorneys fees (655.010). Comparative negligence rule (655.065).
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	Prohibited (655.009).
WY	Panels and Arbitration	
	Statute of Limitations/Repose	2 years from act, but if discovered in 2nd year plaintiff gets six month extension. If discovered after two years, plaintiff has 2 years from discovery. (Wyo. Stat. 1-3-107).
	Limitation on Recoveries and Fees	Medical Malpractice Fund established. Mandatory insurance of $50,000; medical liability compensation account pays excess up to $1,000,000. (26-40-106).
	Collateral Source Rule	
	Standard of Care	
	Ad Damnum Clause	

Chairman JACOBS. Statistical Abstract of the United States

Mr. BENDORF. Yes, a Federal document.

Chairman JACOBS. Who is that?

Mr. BENDORF. That is the U.S. Government. A Government Printing Office publication. The sources of each of the figures in the Statistical Abstract are usually cited by the abstract.

Chairman JACOBS. Eighty percent of those who are employed have contracts through employment to continue their wages in case they have a——

Mr. BENDORF. They have some sort of wage continuation plan just as everyone in the room probably has, certainly every Federal employee, certainly every public employee, most large corporate employees, most labor represented individuals and that is what the 80 percent represents.

Chairman JACOBS. You say certainly with respect to them. I assume you mean something less than certain with respect to others?

Mr. BENDORF. Pardon me?

Chairman JACOBS. If you say certainly with respect to the public employees, I assume or I infer you have to say something less than certain with regard to the other citizens?

Mr. BENDORF. Correct. You will ultimately get down to the 20 percent after you have addressed yourself to the obvious ones. So there is—if you apply these small percentages to those likely to be injured, you are going to find that those individuals who are absolutely dependent on some sort of recovery represent a very, very tiny statistical portion of the universe.

Chairman JACOBS. Mr. Bendorf, you have said that you are distinguished among witnesses here today because you deal in facts. There was one that I was curious about. Can you tell me how much money the trial lawyers in Baton Rouge raised so far to defeat Mr. Moore in the upcoming elections?

Mr. BENDORF. I have no idea. I can tell you that we have offered Mr. Moore support from our political action committee in every one of his elections and I would certainly expect to do it again this year. I am not aware of any effort being made. I am aware of the Federal political action committee that the trial lawyers have and I know they don't even know at this time what the name of his opponent is if he has one. I am stating this for the record.

Chairman JACOBS. Let me just give a fact to you as told to me by Mr. Moore earlier. He said that there was a well advertised and concentrated effort by the trial lawyers in Baton Rouge, LA—is that where he is from—yes—to raise funds, I say it is well publicized, to obtain his defeat this fall. There is nothing wrong, but I just——

Mr. BENDORF. I can only say I have no knowledge of it. That has not been brought to our attention and ours is the political PAC that makes contributions to Congressmen and Senators. So it is a subject about which I have no knowledge.

Chairman JACOBS. Mr. Moore has distinguished himself then by knowing that fact apparently.

Mr. BENDORF. I must say this because I have indicated our offers of support that he is one of the Congressmen who has never accept-

ed contributions from political action committees I believe. At least certainly from ours over the years.

Chairman JACOBS. In my own case I think I could forgive him for that.

I would like to ask both of you the same question I asked the previous panels about the Indiana law. Are either of you familiar with it, A; and B, do either of you have a kind or unkind thing to say about it?

Mr. METZGER. If I may answer, I am familiar generally, Mr. Chairman, of the law but I really have no comment as it might apply in Florida. I would be concerned as a lawyer as to its ultimate fate in Florida on a constitutional basis.

Chairman JACOBS. You mean with respect to specifically the cap.

Mr. METZGER. The cap, yes, sir.

Chairman JACOBS. Mr. Bendorf?

Mr. BENDORF. I don't have specific information about Indiana. I can have before the day is over and I can give you and I will, a comparison of those laws nationwide. The caps have been determined to be violative of the equal protection in a number of States, particularly where the cap is for medical malpractice alone. There are other States where a cap for medical malpractice alone has been upheld and I would be delighted to provide you with a review of all of those.

Chairman JACOBS. I am informed by one of my betters that there has been a test to the highest court of Indiana, I am not certain whether the U.S. Supreme Court has ruled on the U.S. constitutionality of the statute. Do you have anything legislatively in order to change the present situation and I won't prejudice the question.

Mr. BENDORF. May I take advantage of the fact that this is the Ways and Means Committee and suggest one thing.

Chairman JACOBS. Why not, everybody else does.

Mr. BENDORF. I thought you might allow it. The estimate of incurred losses is made for each year on the 31st day of December, and in the 1st year in which that estimate is made that amount is deducted from current income. I have been unable to get this answer from the Internal Revenue Service and when I say I have been unable to get it the answer is "We don't know."

But the doctors are providing about 1 percent of the casualty premiums and they are providing about 5 percent of the investment income. St. Paul, the largest commercial underwriter of medical malpractice insurance originally estimated that there incurred losses and they therefore deduct it against current income, losses and expenses would be $38 million. They currently estimate $27 million.

So all the deductions in 1975, they are showing a lesser amount at the present time from then. The presumption of course is that because insurance is a prospective business and because it has its own internal revenue code, one for you and me, one for the casualty industry, and one for the life industry, that this is part of being a prospective business. But St. Paul's has since 1975 reduced its estimate of incurred $196,062,000 in medical malpractice. That amount obviously incurs no penalties and no interest.

The question that I have asked is, Is it appropriate for the IRS to examine only the bottom line of a major corporation or is it appro-

priate to examine each element, and the reason I ask that is because I don't feel that it is appropriate to gouge doctors in order to be more competitive in homeowners or in automobile liability or something like that. In no other lines do you find this drastic reduction of the original estimate of incurred losses and in no other lines do you find this kind of investment income.

I think that is an appropriate subject for the committee most interested in income tax to examine. What is the obligation to protect any particular element of society and determine that they are being fairly treated, particularly where there are these kinds of tax implications?

Thank you.

Chairman JACOBS. Good. We thank the panel for the enrichment of the record. We are very grateful. And to think I almost skipped over that panel.

Our next panel is Melvin Levitt, on behalf of the American Association of Retired Persons; and Mark S. Thompson, associate professor, Harvard University School of Public Health.

STATEMENT OF MELVIN LEVITT, ON BEHALF OF THE NATIONAL LEGISLATIVE COUNCIL OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY MEREDITH COTE, STAFF MEMBER

Mr. LEVITT. I am Melvin Levitt, without an "e" on it. I would like to introduce Meredith Cote, a member of our staff. We have submitted an indepth paper, but I would like to make a few remarks.

I thank you for this opportunity to share with the subcommittee the AARP's concerns in the area of medical malpractice. As you are aware, AARP is deeply concerned about what is happening in the health-care sector of the economy. As we press for health care cost containment, the issue of medical malpractice has been equally pressed by the medical community. But the problem of medical malpractice is only one element of the more general difficulties we are experiencing with our medical care system.

To treat medical malpractice as a separate issue may well prove detrimental in its overall consequences for the health care system. The challenge before the subcommittee, then, is to take the time to ensure that the issue is well thought through, and that proposed remedies do not cause other unanticipated problems.

There are those who would argue that we are in the midst of a malpractice crisis. Although it cannot be denied that malpractice premiums have risen dramatically since the early 1970's, it appears that only selected specialties in selected geographic areas are bearing a substantial financial burden.

The last several years have witnessed premiums that have been relatively stable. In 1982, the average medical liability premium, across all specialties, was $5,800. In the same year, the average gross income of physicians was $178,000. The average premium increased 9.5 percent in 1983.

Since 1978, the average medical liability premium expressed as a percentage of physician average gross income has actually declined: In 1978, premiums were 3.9 percent of gross income; in 1982, premi-

ums were only 3.2 percent of gross income. Although there is evidence to suggest that physicians shift all such costs to patients, it appears that malpractice protection is a small percentage of most physicians' actual costs of doing business.

AARP is concerned that the issue of medical malpractice litigation may be eclipsing the real issue brought to light by the malpractice problem: The fact of malpractice itself. There must be a more concerted effort to control or mitigate the actual occurrences of malpractice and the medical environment which may induce malpractice claims. Providers must take steps that indicate awareness that the malpractice problem did not derive entirely from shortcomings in the legal system or insurance practices.

Since hospital admission rates for the elderly are roughly twice as high as those for younger persons and the rate of negligent injury per admission is roughly twice as high for the elderly, the evidence of no significant difference in claim frequency between the elderly and the rest of the population suggests that the probability of an elderly person's filing a claim, given a potentially actionable injury, is roughly one-fourth that for persons under 45.

Not only are the elderly not filing the claims that physicians allege lead to the practice of defensive medicine, but it is very likely that the medicare system pays twice in instances where injury occurs. Rather than focusing on the problem after the injury has occurred, AARP urges the providers of care to examine their own contribution to the development of the problem.

The problems of medical malpractice are inextricably linked to the problems of quality of care. As risk management becomes increasingly popular in the hospital setting in order to prevent financial losses from litigation, the goal of such programs should be to integrate risk management and quality assurance into a unified quality control program. Only in this way will the demand for public accountability be met and the growing role of the health care consumer be realized.

Physicians have long claimed that they are the ones who should regulate the quality of medical care. However, their record as measured by license suspension or revocation, is indefensible. Physician groups have either refused or been unable to regulate their members and State-designated regulatory agencies have refused to police their licensees.

Despite this record, we still posit that it is the responsibility of the profession to develop standards of performance for services and procedures and to establish institutions and methods for monitoring the enforcement of such standards.

In order to protect quality of care and to prevent litigation, we expect that the medical profession will be technically competent—but that it is not all we expect. Physicians should clean up their act.

H.R. 5400 affords health care providers the opportunity to limit their liability for acts of professional malpractice. Although the bill's intent is to simplify the malpractice system to the betterment of all parties, AARP questions the extent to which it will create any significant improvements over the current system.

The new system contemplated by the bill applies to claims arising from federally funded programs. The extent to which such

claims contribute to a malpractice problem—real or imagined—is unclear. Certainly, with respect to claims arising under medicare, the largest Federal program included in the bill, any benefits resulting from this system will likely be insignificant.

The elderly, as a group, file far fewer claims than the population as a whole. Further, because compensable loss and hence the payoff from suing declines with age, malpractice suits involving elderly claimants generally do not give rise to excessively large judgments. An alternative system which is largely directed to an elderly patient population, who for the most part are not causing the alleged problems, is unlikely to have a substantial impact.

The incentives for States to adopt a similar system for all malpractice claims appear to be weak. We cannot be confident that the States will be quick to adopt this system.

As drafted, the bill gives providers the option of availing themselves of the no-fault system. A provider can choose to tender an offer to a victim of malpractice, covering net economic loss, thus limiting its liability and barring the patient from bringing a civil lawsuit. The incentive would be for the provider to make such an offer in the particularly egregious cases where their liability is clear.

In closer cases, the incentive would be for the provider to resist making a settlement offer. This is particularly so if the patient is an elderly person who, for various reasons, is unlikely to file a lawsuit. In short, the provider has the option of using the new system when it will be to its advantage and to avoid it when it will not.

Nothing in the bill creates the incentive to reduce the incidences of medical malpractice, which should be the overriding goal. In fact, enabling providers to limit liability may indeed cause them to be less vigilant in maintaining a standard of care. Weeding out chronically negligent providers would do more toward reducing malpractice and premiums than would limiting recovery for victims of poorly practiced medicine.

I have heard here that the plaintiff only gets 27 cents out of the dollar in a lawsuit for malpractice, and I have heard 80 percent of the cases are decided for the defendant. Getting away from my statement, I wonder why something isn't done about limiting the amount that attorneys get when you have a contingency case. Why must it be 30, 40, 50 percent? Why shouldn't it be 10 percent? Maybe there would be something in this procedure that would stop some of these lawsuits.

In conclusion, resolutions of problems facing the health care industry, including those revolving around the issue of malpractice, defy easy solutions. The system suffers throughout from inappropriate incentives. Upon examination, we are not convinced that H.R. 5400 adequately addresses the malpractice issue, for despite its good intentions, it falls short of a comprehensive approach.

AARP looks forward to continuing to work with the sponsors of this bill and other Members of Congress to improve health care delivery for the elderly and all Americans.

Thank you.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS, PRESENTED BY MELVIN LEVITT OF THE NATIONAL LEGISLATIVE COUNCIL

SUMMARY

1. AARP is deeply concerned about what is happening in the health care sector of the economy. If health care costs continue to escalate as they have, accessible and affordable health care services will cease to be available to millions of Americans.

2. Medical malpractice reflects the more general difficulties we are experiencing with our medical care system. Since it is one element, we must take the time to fully identify all the problems and their causes and must avoid the temptation of opting for fragmented solutions.

3. Medical malpractice has not reached the "crisis" proportions some would have us believe. In fact, since 1978, the average medical liability premium expressed as a percentage of physician average gross income has declined.

4. The real issue brought to light by the malpractice problem is that there must be a more concerted effort to control or mitigate the actual occurrences of malpractice and the medical environment which may induce malpractice claims.

5. The problems of medical malpractice are inextricable linked to the problems of quality care. As risk management becomes increasingly popular in the hospital setting in order to prevent financial losses from litigation, the goal of such programs should be to integrate risk management and quality assurance into a unified quality control program.

6. The medical profession should match the constant talk of "quality medicine" with more effective institutions and procedures to ensure that such quality medicine is actually getting to the patient.

7. H.R. 5400—The Alternative Medical Liability Act:

The bill affords health care providers the opportunity to limit their liability for acts of professional malpractice. AARP questions the extent to which it will create any significant improvement over the current system.

An alternative system which is largely directed to an elderly patient population that as a group files far fewer claims than the population as a whole is unlikely to have a substantial impact.

The incentives created by the bill do not appear to be fairly balanced. The provider can force the patient to accept a settlement covering net economic loss but the patient has no means to induce such a settlement from an unwilling provider.

Nothing in the bill creates an incentive to reduce the incidences of medical malpractice, which should be the overriding goal.

The practice of defensive medicine is likely to remain unaffected.

The simplification of the system envisioned by the bill may not be nearly as pronounced as expected.

STATEMENT

Thank you, Mr. Chairman, for this opportunity to share with the Subcommittee the American Association of Retired Persons' (AARP) concerns in the area of medical malpractice. As you are aware, AARP is deeply concerned about what is happening in the health care sector of the economy. If health care costs continue to escalate as they have, accessible and affordable health care services will cease to be available to millions of Americans. As we press for health care cost containment, the issue of medical malpractice has been equally pressed by the medical community. But the problem of medical malpractice is only one element of the more general difficulties we are experiencing with our medical care system. To treat medical malpractice as a separate issue may well prove detrimental in its overall consequences for the health care system. The challenge before the Subcommittee, then, is to take the time to ensure that the issue is well thought through, and that proposed remedies do not cause other unanticipated problems.

Medical malpractice in prospective

There are those who would argue that we are in the midst of a malpractice "crisis". Although it cannot be denied that malpractice premiums have risen dramatically since the early 1970's, it appears that only selected specialties in selected geographic areas are bearing a substantial financial burden. The last several years have witnessed premiums that have been relatively stable. In 1982, the average medical liability premium (across all specialties) was $5,800. In the same year the average gross income of physicians was $178,000. The average premium increased 9.5% in 1983. Since 1978, the average medical liability premium expressed as a percentage of physician average gross income has actually declined: in 1978 premiums

were 3.9% of gross income; in 1982 premiums were only 3.2% of gross income. Although there is evidence to suggest that physicians shift all such costs to patients, it appears that malpractice protection is a small percentage of most physicians' actual costs of doing business.

In citing a malpractice "crisis" there are those who point to dramatic increases in the rate of claims filed and the severity of the award per claim from the early 1970's to the present. These increases must be placed in perspective: First, although there has been a dramatic increase in the frequency of claims, this fact is not so dramatic when you consider that the baseline for comparison was low since there were so few claims filed prior to the mid 1970's. Second, only in rare cases will the level of litigation reach the level of occurrence of incidents. It has been estimated that 5 patients per 100 sustain an iatrogenic injury (that is, an injury imputed to medical treatment itself rather than prior medical condition). Yet only a fraction of the total number of iatrogenic injuries are potentially actionable under the negligence system. And relatively few negligent incidents ever result in claims, much less litigation. Fewer than 10% of claims are tried to verdict; of those, the plaintiff only wins 25% of the time. And then there is the possibility that the award may be overturned or reduced on appeal. Simply stated, when examined in both absolute numbers and relative to the total number of potentially actionable incidents that occur, there is no crisis.

Medical malpractice and the elderly

AARP is concerned that the issue of medical malpractice litigation may be eclipsing the real issue brought to light by the malpractice problem: There must be a more concerted effort to control or mitigate the actual occurrences of malpractice and the medical environment which may induce malpractice claims. Providers must take steps that indicate awareness that the malpractice problem did not derive entirely from shortcomings in the legal system or insurance practices.

Since hospital admission rates for the elderly are roughly twice as high as those for younger persons and the rate of negligent injury per admission is roughly twice as high for the elderly, the evidence of no significant difference in claim frequency between the elderly and the rest of the population suggests that the probability of an elderly person's filing a claim, given a potentially actionable injury, is roughly one-fourth that for persons under 45. Not only are the elderly not filing the claims that physicians allege lead to the practice of defensive medicine, but is very likely that the Medicare system pays twice in instances where injury occurs. Medicare pays the first time for the initial treatment and, to the extent that an injury occurs, Medicare pays for its subsequent reparation. Rather than focusing on the problem after the injury has occurred, AARP urges the providers of care to examine their own contribution to the development of the problem.

A provider approach to medical malpractice

The problems of medical malpractice are inextricably linked to the problems of quality of care. As risk management becomes increasingly popular in the hospital setting in order to prevent financial losses from litigation, the goal of such programs should be to integrate risk management and quality assurance into a unified quality control program. Only in this way will the demand for public accountability be met and the growing role of the health care consumer be realized.

Physicians have long claimed that they are the ones who should regulate the quality of medical care. However, their record as measured by license suspension or revocation, is indefensible. Physician groups have either refused or been unable to regulate their members and state-designed regulatory agencies have refused to police their licensees. Despite this record we still posit that it is the responsibility of the profession to develop standards or performance for services and procedures and to establish institutions and methods for monitoring the enforcement of such standards.

In order to protect quality of care and to prevent litigation we expect that the medical profession will be technically competent. But that it is not all we expect. Evidence suggests that in the event of injury, physicians with poor doctor-patient relationships are more likely to be sued. Whether a good doctor-patient relationship is too much to expect of a doctor is perhaps debatable but the fact that the public wants it is not.

We also expect that there will be institutions and procedures for monitoring care. We have a long way to go before either the profession or the public can be satisfied that incompetence has been reduced to the absolute minimum. The medical profession should match the constant talk of "quality medicine" with more effective insti-

tutions and procedures to make sure that such quality medicine is actually getting to the patients.

Finally, we expect intervention or corrective action when necessary. The magnitude of the intervention may range from the issuance of a simple memo to the suspension of medical staff privileges or license revocation. This step is the ultimate test of the profession's seriousness with respect to assuring quality care on behalf of the public.

In summary, the medical malpractice issue is complex and multidimensional. The problems of malpractice will probably never be eliminated by either the tort system or proposed "no fault" systems. The rapidly escalating economic status of physicians combined with the growing perception of hospitals as "big business" have produced serious concerns that providers are not acting in the public interest. These concerns have been bolstered by accounts of actual incompetence that have gone uncorrected. Providers can go a long way toward the actual prevention of malpractice and the improvement of the medical environment which might induce malpractice claims.

H.R. 5400—Alternative Medical Liability Act

H.R. 5400 affords health care providers the opportunity to limit their liability for acts of professional malpractice. Although the bill's intent is to simplify the malpractice system to the betterment of all parties, AARP questions the extent to which it will create any significant improvements over the current system.

The new system contemplated by the bill applies to claims arising from federally funded programs. The extent to which such claims contribute to a malpractice problem—real or imagined—is unclear. Certainly with respect to claims arising under Medicare, the largest federal program included in the bill, any benefits resulting from this system will likely be insignificant. The elderly as a group file far fewer claims than the population as a whole. Further, because compensable loss and hence the payoff from suing declines with age, malpractice suits involving elderly claimants generally do not give rise to excessively large judgements. An alternative system which is largely directed to an elderly patient population, who for the most part are not causing the alleged problems, is unlikely to have a substantial impact.

The incentives for states to adopt a similar system for all malpractice claims appear to be weak. We cannot be confident that the states will be quick to adopt this system.

As drafted, the bill gives providers the option of availing themselves of the no-fault system. A provider can choose to tender an offer to a victim of malpractice thus limiting its liability and barring the patient from bringing a civil lawsuit. The incentive would be for the provider to make such an offer in the particularly egregious cases where their liability is clear. In closer cases the incentive would be for the provider to resist making a settlement offer. This is particularly so if the patient is an elderly person who for various reasons is unlikely to file a lawsuit. In short, the provider has the option of using the new system when it will be to its advantage and to avoid it when it will not.

The incentives created by this bill do not appear to be fairly balanced. The provider can force the patient to accept a settlement covering net economic loss. On the other hand, the patient has no means to induce such a settlement from an unwilling provider. Nothing in the bill, however, creates an incentive to reduce the incidences of medical malpractice, which should be the overriding goal. In fact, enabling providers to limit their liability may indeed cause them to be less vigilent in maintaining a standard of care. Weeding out chronically negligent providers would do more toward reducing malpractice judgements and premiums than would limiting recovery for the victims of poorly practiced medicine.

The only situations where a provider cannot foreclose a lawsuit would be in the case of a wrongful death or intentional misconduct. Intentional misconduct is defined such that it would likely exclude all but criminal conduct. Thus, even in a case of gross negligence a provider may immunize itself from a civil suit by offering compensation.

To the extent that the practice of defensive medicine resulting from providers, desire to insulate themselves from liability unnecessarily raises health care costs, it is unclear that the bill offers significant improvement.

The practice of defensive medicine, (i.e, performing an array of tests and procedures of dubious value in most cases), is said to result from fear on the part of providers that the failure to practice in such a manner will expose them to malpractice liability. Nothing in H.R. 5400 precludes patients from bringing lawsuits based on providers' failure to perform a certain "defensive" procedure as they might under the current system. Though H.R. 5400 would enable a provider to foreclose such a suit, this can only be done by offering to compensate the patient for net economic

loss. Faced with the option of being either sued or offering limited compensation it would still seem most prudent for a provider to continue to practice in a defensive manner in the hope of avoiding situations of potential financial exposure altogether.

Beyond the question of whether H.R. 5400 adequately addresses the malpractice issue, we are concerned that the simplification of the system envisioned by H.R. 5400 may not be nearly as pronounced as expected. If, in a particular situation, net economic loss turns out to be a substantial sum there is likely to be dispute over what should and should not be included as compensable. This could lead to full use of the discovery process permitted under the bill, thus subjecting the patient to much of the inconvenience and expense of litigation that the bill is supposedly designed to avoid.

In a given case any or all of the following issues may become relevant and thus discoverable: the patient's work and earning records, treatment received by the patient and its appropriateness, the patient's mental or physical condition, whether the patient made adequate efforts to mitigage damages and whether expenses incurred by the patient properly fall within the statutory definition of economic loss.

The discovery process is also likely to be utilized in the case of a lump sum settlement requiring court approval. The court will need to be presented with all the pertinent information in order to make an intelligent decision as to whether or not to approve a proposed settlement.

In addition, the problem of allocating responsibility for payment among various providers still exists. The bill would require arbitration on this matter, with each party's share being based on comparative fault. The bill, however, removes the concept of fault from the responsibility to compensate. Since no record of fault will have been established, this will have to be done during the arbitration process and is likely to be time consuming and expensive. While in a sense this is not of concern to the patient, it is likely to affect them indirectly as the ease with which comparative responsibility can be settled will no doubt affect their actually receiving compensation. Further, if a provider must, in essence, litigate the issue of fault anyway, there will be less of an incentive on their part to avoid a tort lawsuit.

Resolutions of problems facing the health care system, including those revolving around the issue of malpractice, dcfy easy solutions. The system suffers thoughout from inappropriate incentives. Upon examination we are not convinced that H.R. 5400 adequately addresses the malpractice issue, for despite its good intentions it falls short of a comprehensive approach.

This does not mean that solutions to health care problems are beyond our reach. We must, however, take the time to fully identify these problems and their causes and avoid the temptation of opting for fragmented solutions. AARP looks forward to continuing to work with the sponsors of H.R. 5400 and other members of Congress to improve health care delivery for the elderly and all Americans.

Chairman JACOBS. Mr. Thompson.

STATEMENT OF MARK S. THOMPSON, PH.D., ASSOCIATE PROFESSOR OF HEALTH POLICY AND MANAGEMENT, HARVARD UNIVERSITY SCHOOL OF PUBLIC HEALTH

Mr. THOMPSON. Mr. Chairman, three arguments have traditionally been put forward in justification of the present litigation-based system for dealing with medical malpractice in the United States: first, compensation, that litigation helps to transfer money to persons with extraordinary financial needs as a result of medical injuries; second, justice, that the right to sue providers of health care for the harm caused by their negligence is fundamental; and third, quality of care, that the threat of lawsuit leads physicians to practice medical care of a higher standard.

While there is some truth in each of these premises, research of my own and of colleagues suggests that on all three of these counts, the system embodied in H.R. 5400 would be distinctly superior to the present system.

On the issue of compensation, recent studies indicate that of every 140 persons suffering medical injuries during hospitalization, only 1 of those 140 receives compensation through the current med-

ical malpractice system. Those awards or out-of-court settlements that are received are almost totally paid for from medical malpractice insurance. In comparison with other systems of compensation, medical malpractice insurance is distressingly inefficient. For every dollar paid into the system as premiums, only 30 cents is paid to injured patients; the other 70 cents goes toward the expenses and profits of insurance companies, legal fees, expert witness honoraria, and the like.

Besides being inefficient, the present system is unfair. Imagine, if you will, three identical sequences of medical events. It is quite possible that, in one case, no liability will be found; in the second, that liability will be found and an award of $100,000 made; in the third, an award of $1.5 million. Some patients, thus, receive considerable awards, while others in the same circumstances receive nothing. Some physicians are judged not negligent, while others who have committed the same acts are found negligent and are thus professionally and personally stigmatized for life. The present system is highly random because some patients are more aggressive and litigious than others, because of the whims of juries, because neither judges nor juries know what to make of expert witness testimony, and because juries have poor guidance in determining award amounts.

Authorities on physician behavior and physicians themselves agree that the threat of lawsuit does not lead physicians to enhance the quality of the medical care they provide. Instead, the threat of lawsuit leads to what is known as defensive medicine: actions taken by providers of health care to reduce the likelihood that patients will bring lawsuits against them or to improve their legal defense in the event of a lawsuit. Between 50 and 80 percent of all physicians admit to practicing defensively. On the basis of a series of interviews with doctors, it is our estimate that defensive medicine in the United States comprises 9 percent of invasive diagnostic procedures and other surgery, 29 percent of medical tests, 12 percent of other hospital expenditures, 23 percent of nonsurgical physician charges, 8 percent of payments for drugs, eyeglasses, devices and appliances, and 4 percent of nursing home care, for an overall total of 14 percent of the total expenditures on health care in the United States each year—well over $40 billion in 1984. Many of these expenses will bring some limited benefit to patients, but many more are not just unnecessary but also dangerous. One tragic example is the rate of cesarean sectioning. Obstetricians and other physicians estimate that 200,000 cesarean sectionings are performed in the United States each year, not because they are medically indicated, but rather due to fears of lawsuits. These operations carry risks for both mother and baby, and approximately eight maternal deaths result each year in the U.S. from these unnecessary cesarean sectionings.

Having considered these factors, it is my personal opinion that passage of H.R. 5400, as introduced by Representatives Moore and Gephardt, has advantages far in excess of any disadvantages. The most significant potential disadvantage is that a relatively small number of deserving patients would no longer be able to receive sizable awards for their pain and suffering.

The advantages are that the bill: One, would provide compensation to many more injured patients in need of financial support than is the case under the present system; two, would significantly reduce the delays, the acrimony, and other aggravations in the present system; three, would facilitate more systematic, consistent, and fair procedures in the determination of awards; four, would enhance the quality of medical care; and five, would save patients and taxpayers $40 billion annually by reducing administrative and legal costs and by largely removing the incentive for defensive medical practice.

H.R. 5400 merits serious consideration by this committee.

Thank you.

[The prepared statement follows:]

STATEMENT OF MARK S. THOMPSON, PH.D., ASSOCIATE PROFESSOR OF HEALTH POLICY AND MANAGEMENT, HARVARD UNIVERSITY SCHOOL OF PUBLIC HEALTH

Three arguments have traditionally been put forward in justification of the present, litigation-based system for dealing with medical malpractice in the United States:

(1) compensation—that litigation helps to transfer money to persons with extraordinary financial needs as a result of medical injuries;

(2) justice—that the right to sue providers of health care for the harm caused by their negligence is fundamental; and

(3) quality of care—that the threat of lawsuit leads physicians to practice medical care of a higher standard.

While there is some truth in each of these premises, research of my own and of colleagues suggests that on all three of these counts the system embodied in H.R 5400 would be distinctly superior to the present system.

COMPENSATION

On the issue of compensation, recent studies [1,2] indicate that of every 140 persons suffering medical injuries during hospitalization, only one of those 140 receives compensation through the current medical malpractice system. Those awards or out-of-court settlements that are received are almost totally paid for from medical malpractice insurance. In comparison with other systems of compensation, medical malpractice insurance is distressingly inefficient: for every dollar paid into the system as premiums, only 30 cents is paid to injured patients [3]. The other 70 cents goes toward the expenses and profits of insurance companies, legal fees, expert witness honoraria, and the like.

JUSTICE

Besides being inefficient, the present system is unfair [4,5]. Imagine, if you will, three identical sequences of medical events. It is quite possible that, in one case, no liability will be found; in the second, that liability will be found and an award of $100,000 made; in the third, an award of $1.5 million. Some patients thus receive considerable awards, while others in the same circumstances receive nothing. Some physicians are judged not negligent, while others who have committed the same acts are found negligent and are thus professionally and personally stigmatized for life. The present system is highly random because some patients are more aggressive and litigious than others, because of the whims of juries, because neither judges nor juries know what to make of expert witness testimony, and because juries have poor guidance in determining award amounts.

QUALITY OF CARE

Authorities on physician behavior [6,7] and physicians themselves agree that the threat of lawsuit does not lead physicians to enhance the quality of the medical care they provide. Instead, the threat of lawsuit leads to what is known as defensive medicine: actions taken by providers of health care to reduce the likelihood that patients will bring lawsuits against them or to improve their legal defense in the event of a lawsuit. Between 50 and 80 percent of all physicians admit to practicing defensively [8–11]. On the basis of a series of interviews with doctors [12], it is our

estimate that $42 billion will be spent on defensive medicine in the U.S. in 1984. Over half of this amount will derive from unnecessary invasive diagnostic procedures, excessive medical testing, and unneeded days of hospitalization. Many of these expenses bring some limited benefit to patients, but many more are not just unnecessary but also dangerous. One tragic example is the rate of cesarean sectioning. Obstetricians and other physicians estimate that 200,000 cesarean sectionings are performed in the United States each year not because they are medically indicated but rather due to fears of lawsuits. These operations carry risks for both mother and baby and approximately eight maternal deaths result each year in the U.S. from these unnecessary cesarean sectionings.

CONCLUSION

Having considered these factors, it is my personal opinion that passage of H.R. 5400, as introduced by Representatives Moore and Gephardt, has advantages far in excess of any disadvantages. The most signficant potential disadvantage is that a relatively small number of deserving patients would no longer be able to receive sizable awards for their pain and suffering. The advantages are that the bill:

(1) would provide compensation to many more injured patients in need of financial support than is the case under the present system;

(2) would significantly reduce the delays, the acrimony, and other aggravations in the present system;

(3) would facilitate more systematic, consistent, and fair procedures in the determination of awards;

(4) would enhance the quality of medical care; and

(5) would save patients and taxpayers $40 billion annually by reducing administrative and legal costs and by largely removing the incentive for defensive medical practice.

H.R. 5400 merits serious consideration by this Committee.

NOTES

(1) Pocincki, L.S., Dogger, S.J., and Schwartz, B.P., "The Incidence of Iatrogenic Injuries," Report of the Secretary's Commission on Medical Malpractice: Appendix, Department of Health, Education, and Welfare Publication 05-73-89 (Washington, D.C., 1973).

(2) California Medical Association and California Hospital Association, Medical Insurance Feasibility Study (San Francisco: Sutter Publications, 1977).

(3) This is a compromise estimate among the calculations of many studies, including those reviewed by P. Munch, Costs and Benefits of the Tort System if Viewed as a Compensation System (Santa Monica, CA: Rand, 1977).

(4) Danzon, P.M., The Disposition of Medical Malpractice Claims (Santa Monica, CA: Rand, 1980).

(5) Smith, R., "Compensation for Drug Injury: Problems Both Sides of the Atlantic," British Medical Journal 282: 1443-1445, 1981.

(6) Brook, R.H. "The Relationship Between Medical Malpractice and Quality of Care," pp. 19-53 in Medical Malpractice: the Duke Law Journal Symposium (Cambridge, MA: Ballinger, 1977).

(7) Schwartz, W.B., and Komesar, J.D., "Doctors, Damages, and Deterrence," New England Journal of Medicine 298: 1282-1289, 1978.

(8) Duke Law Journal, "The Medical Malpractice Threat: A Study of Defensive Medicine," 939-993, 1971.

(9) Medical Economics, "Making Your Practice More Malpractice-Proof," September 30, 1974: 69-130.

(10) Lipson, A.J., Medical Malpractice: The Response of Physicians to Premium Increases in California, (Santa Monica, CA: Rand, 1976).

(11) Lander, L., Defective Medicine: Risk, Anger, and the Malpractice Crisis, (New York: Farrar, Straus, and Giroux, 1978).

(12) Thompson, M.S., and King, C.P., "Physician Perceptions of Medical Malpractice Processes and Defensive Medicine," Evaluation and Program Planning, in press, 1984.

Chairman JACOBS. I thank the panel for its testimony.

Mr. Moore.

Mr. MOORE. Thank you, Mr. Chairman.

Dr. Thompson, I especially appreciate your comments. They are very learned and very helpful. They give us a scholarly outlook on what is a very nettlesome problem.

Mr. Levitt, I don't disagree with any of the things you testified to. And, believe me, all of these things are of concern to us. As you know, we have worked closely with AARP during the entire conceptualization of this bill, because how you all think about this is important to us.

We appreciate the fact you are still maintaining an open mind to the legislation, although you do have serious questions. One of the points you made in your testimony was that an alternative system, directed to an elderly population not filing suits to the same degree as the rest of the population, is unlikely to have an impact on the elderly.

My only comment is for you to consider this, as we consider your testimony. One of the reasons we have been led to believe the elderly don't file suits is that they hesitate to initiate the action of going to a lawyer and suing their doctor.

Under this bill, they don't have to overcome that obstacle. The doctor and the hospital come to them. That is why we have reason to believe that there will be an increase in awards to elderly patients over what you are finding in the tort system now.

Do you have any comment?

Mr. LEVITT. Congressman, I wish I was as assured as you seem to be that when an elderly person under this bill does not seek out a lawyer, that the physician is going to come along and say, "I made a mistake and I am now offering you some money." I doubt seriously if that ever is going to happen.

The fact of the matter is, if the plaintiff is not the crying baby, he will not get the milk. If the elderly people don't make a claim, I doubt seriously if the physicians are going to come forward and say, "Hey, we owe you some money." I don't think that will happen. I think they will fall through the cracks.

Mr. MOORE. If this becomes law, that will be the proof of the pudding.

We have changed the bill partly out of response to your concerns. In the beginning, we thought of having this bill require a positive statement or request for payment or claim to be filed by certified letter short of a lawsuit by the aggrieved party or the elderly, as concerns you. We decided to discard that to prevent the situation of having the elderly person faced with the same difficult choice they are evidently being faced with now in the tort system, and that is not wanting to initiate the action for fear of not being treated when they are ill.

You make the comment you doubt a physician would come forth and admit he is wrong. That is part of the good of the system—there is no admission of wrong. You never get to the question of fault; just as you don't reach the question of fault when an insurance company settles prior to trial today.

You heard Dr. Stewart testify earlier. He is afraid of the opposite; he is afraid so many tenders will be made it may wind up costing more. Indeed, we have had insurance companies that testified to the same thing. Insurers asked us to expand the scope of the bill from our original thought of only covering medicare, because they

thought they would be paying out more than they would be saving because of the low frequency of suits being currently filed by elderly citizens.

The second point that interested me is that you agree the provider can force the patient to accept a settlement of economic loss while taking away the right to sue for noneconomic loss. But you are concerned that the patient has no means to induce that settlement from an unwilling provider.

My comment is that is the case now in the tort system. Under the alternative system, if the hospital or the physician refuses to tender any settlement to an injured party, their redress is the tort system. It is not different than now. The situation remains the same.

Ms. COTE. If I might add something——

Mr. MOORE. I am not sure your name is in the record.

Ms. COTE. Meredith Cote, AARP legislative representative.

I would only add, for your consideration, Congressman Moore, it seems that we are putting a lot of burden on the physicians in deferring to their altruism in wanting to come forth and tender an offer.

What I am concerned about is that just from the mere fact we all know that the elderly are less likely to sue, what is going to make the physician come forward to propose a settlement? One thing might be a fear of a subsequent lawsuit.

My only concern is, if the physician is armed with the same information we are, that is, that the elderly population is less likely to sue, by not tendering an offer they are often saying that they know that the potential patient is not going to sue. So the whole idea seems to work both ways, as far as we can see.

Unless you have got something that will really motivate the physician to come forward—and we might submit that perhaps built into the bill might be language that any iatrogenic illness might be compensated for rather than just where the physician thinks he or she might be negligent.

Mr. MOORE. I understand and agree that what you say may be possible. On the other hand, it may not work that way.

I don't agree with your comment that physicians will come forward in altruistic manner; they will come forward to take care of a case that they know or the hospital knows or the insurer knows is a potential claim as a way of settling that claim and getting rid of it and not facing a potential lawsuit. Even though elderly are not likely to sue, according to the Rand studies, some still do.

The physician is running the risk that he may be the one sued. If so, you are not any worse off. We have not taken away anything from the patient who will not sue. We have given them an opportunity that they may be tendered an offer which they are not getting now.

Wouldn't you say it could be true?

Ms. COTE. I would like to take one opportunity to comment on the defensive medicine, and the fact it is alleged this bill may cut down on that practice. The only query I tender is this: Why is it alleged that defensive medicine is practiced? Because there is a fear of potential lawsuit. To the extent that a physician is going to be fully reimbursed under our current methods of reimbursement

for all defensive medicine, why not just continue along those lines and, therefore, preclude not only a lawsuit but preclude the need to offer any kind of compensation in a tender situation? In other words faced with the option of being either sued or offering compensation, it would seen that a provider would continue the defensive practices in the hope of avoiding potential financial exposure altogether.

So I don't see where there is significant incentive to stop defensive medicine, assuming they will be compensated by the system.

Mr. MOORE. Based on the evidence we have received, we think that if a physician is not faced with the threat of a lawsuit, he will not offer tests that are unnecessary. Physicians often order tests to prepare for a potential lawsuit.

Likewise, we think that the diagnostic related grouping system of prospective reimbursement is already putting pressure on physicians not to order tests that are unnecessary. It is a combination of those things that will reduce the practice of defensive medicine.

But I would ask if Dr. Thompson has an opinion. He is a greater scholar and student of this area than I.

Mr. THOMPSON. I agree with what you say, Congressman Moore; that indeed a two-part approach to cost containment is in order. First, we should have some sort of reduction in the amount of third-party coverage of all the medicial expenses. Second, we should reduce the incentive to practice defensive medicine. There is substantial evidence from other societies—from England, Sweden, Canada, New Zealand, and others—that defensive medicine can be substantially contained below the levels it is currently at in the United States, and the overall cost of the medical malpractice system can be an order of magnitude less than what we currently have in the United States.

Mr. MOORE. Thank you.

Mr. Chairman, I have no further questions.

I want to thank you for your testimony.

Chairman JACOBS. Mr. Levitt, you suggested the possibility of limiting attorneys' fees. Would you apply that to doctors' fees, as well? Would you suggest limiting doctors' fees, as well?

Mr. LEVITT. Well, frankly, I had not considered it. But now that you bring it up, it might not be a bad idea.

Chairman JACOBS. I thought you might say that.

Mr. LEVITT. I have heard even the gentleman alongside me say that the plaintiff gets only 30 cents of the dollar. Then they say 27 cents now. And I get the impression there is a pervasive idea that the lawyers are going out and seeking these cases and saying, "I will take it and not charge you a dime, but I will take 30, 40, 50 percent." I don't know if that is true; but if it is, if we limited what an attorney can receive in a malpractice case, maybe some of what I just talked about would not be true.

As far as doctors are concerned, I think the marketplace will take care of them because when a doctor becomes too expensive—and they do as they are practicing; you find they raise their rates, and they have done it continuously, and they are far beyond the CPI, 2½ times what the CPI or what the inflation rate was in 1983—the marketplace will take care of it.

If I am on medicare and I am 77 years of age and I cannot afford my doctor, I will search around and find another doctor who might, (a) give me a better rate, or (b) just take assignments.

Chairman JACOBS. Would you be equally as smart if you were shopping for a lawyer?

Mr. LEVITT. I don't have to shop. They come shopping for me. But when they do, they say, "It is not going to cost you. I am taking it on a contingency."

Chairman JACOBS. Assuming a lawyer shopped you out and said it would cost 50 percent of your recovery, would you be smart enough to shop for a lawyer yourself?

Mr. LEVITT. You are talking about a relationship with elderly people. I am one of them. We are possibly about as gullible a group of people as there are around. I don't know whether a frail elderly woman who has some kind of an injury, who has a lawyer come to her—whether or not she will go shopping. I don't know whether she will with a doctor, either, because of the relationship involved.

Chairman JACOBS. That crossed my mind.

So it really—I didn't want to mention plumbers; they are pretty expensive, too, and other people who come around. I am just suggesting that I think the average American might be just a little bit offended at where some contingent legal fees have gone and are going. But I think I would tip-toe rather gingerly in establishing the precedent.

The last time we tried price controls, I believe it was under President Nixon, about 1971?

Mr. LEVITT. Right.

Chairman JACOBS. Got him through the election, but all hell broke loose.

Mr. LEVITT. That is right.

Chairman JACOBS. And the economy broke loose.

So I think we ought to step very carefully in any direction of that kind, even though I share with you an apprehension about reports of excessive legal fees. Also, I don't like excessive plumbers' fees, doctors' fees, or anybody's—but mine, I guess.

Mr. LEVITT. The plumber doesn't affect my health, so I don't care what he does with my pipes. Doctors affect my health. Lawyers don't——

Chairman JACOBS. A plumber affects my health. I had apoplexy by the price, almost.

Mr. LEVITT. I will agree to that; cardiac arrest.

Thank you.

Mr. MOORE. I want to make one comment to Mr. Levitt, if I may.

Mr. Levitt, in the bill we just passed yesterday, H.R. 4170, there is a provision that not many people are aware of that came out of our committees here in the House that was supported strongly by the chairman and myself. For the first time medicare beneficiaries will be given a printed booklet that will show not just which doctors will accept assignment some of the time, but will show you which doctors accept assignment all the time, meaning that now the medicare beneficiary will have a chance in the marketplace to shop and find the doctor who agrees to treat him for what medicare will pay. That is a new thing that has not been done before. We think it is going to be of tremendous assistance in helping to

control health care costs by giving you, the consumer, something to shop with.

I just wanted to make that point.

Mr. LEVITT. Congressman Moore, I took the trouble to go to the Social Security office in Key West and to get the list of physicians who are taking assignment. Some are taking it up to 10 percent; some 20; some 30. And you get it up to some with 80. But on a case-to-case basis, they make a determination from whom they will take assignment and from whom they will not.

Mr. MOORE. I am saying we are publishing the list of those who agreed with medicare to take it all the time. So that doctor's name will be on the list and identified readily for the beneficiaries to know that this doctor agrees to take assignment all the time—not just some of the time.

Mr. LEVITT. That should be an improvement. Thank you very much.

Mr. MOORE. Thank you.

Chairman JACOBS. Our next panel is: Emory Williams from Wilmette, IL; the Washington Business Group on Health, Willis B. Goldbeck, president; and Blue Cross and Blue Shield Association, Linda L. Lanam, executive Washington representative.

Since Mr. Goldbeck is on this panel, let the record show it will probably be a fun panel.

Our first witness is Emory Williams.

STATEMENT OF EMORY WILLIAMS, WILMETTE, IL, CHAIRMAN OF THE BOARD AND PRESIDENT OF THE CHICAGO-MILWAUKEE CORP.

Mr. WILLIAMS. Mr. Chairman, Mr. Moore, I am Emory Williams, chairman of the board and president of the Chicago-Milwaukee Corp. in Chicago, IL; and I was formerly chief financial officer of Sears, Roebuck & Co. I am a trustee of Northwestern Memorial Hospital in Chicago, and a trustee of Emory University in Atlanta, whose medical center includes several hospitals.

I come before you to testify in support of H.R. 5400. As neither a lawyer, doctor, nor insurance executive, I do not necessarily endorse this bill in all its detail. But I am convinced of the rightness of its general approach; to substitute a more sensible insurance orientation for current medical malpractice coverage.

I am acutely aware of how wasteful and dilatory current malpractice litigation can be. Huge amounts are spent by health care providers in funding malpractice insurance premiums, and yet, payment to their patients is infrequent, almost always fortuitous, and always long-delayed.

Bitter accusatory battles, upsetting in the extreme to both health care providers and their patients—ensue, with the only real profit takers apparently being litigators and other middlemen who live off the system.

The American Medical Association studies show that only about a third of the amount of premiums paid for medical malpractice insurance is received by the patients concerned—and in addition, health care providers are forced to practice highly expensive defensive medicine—ordering tests and procedures not dictated by their

medical expertise but by fear of how appearances might later be distorted in litigation.

The cost of these defensive medical procedures, which must ultimately be borne by the patients themselves either directly or indirectly, is much, much larger, perhaps 8 to 10 times larger, than the cost of malpractice insurance premiums. Others can cite detailed data and statistics on the points I have made; and others can also give detailed analysis of the technical provisions of H.R. 5400.

But as a layman, long interested and involved in the delivery of health care services, I have become convinced that as a society we must be concerned about substituting a system which encourages prompt payment for real losses to those relatively few patients inevitably injured in the course of health care to replace the current expensive—and even cruel—lottery of tort liability.

And, as a businessman concerned about the economic loss of health care for employers and employees alike, I am convinced that we must do everything possible to reduce that cost by rationalizing any element of the system which is inequitable, extravagantly expensive and out of control.

By giving health care providers incentives to by-pass the rancor, gamble and delay of litigation, and to use resources currently being spent on, first, lawyers, second, in duplicating amounts already paid by health insurance, and third, to pay a few injured patients amounts far in excess of their actual losses, approaches such as those embodied in H.R. 5400 deserve the careful attention of this committee and the Congress.

A recent experience convinced me that some changes in the current malpractice insurance system is an absolute necessity. One of my friends in Chicago is an experienced, highly competent and successful orthopedic surgeon. I was shocked when he told me that at the beginning of this year he was giving up his surgical practice because of the unaffordable cost of providing malpractice insurance in the amount made necessary by a recent tort award, even though he himself has never been the object of a malpractice suit.

The economic loss to our society caused by a system which discourages the use of highly specialized medical and surgical skills acquired through a long and expensive process of education and training is too great to escape the most critical scrutiny. And the problem is increasing. In 1983, the number of malpractice filings in Cook County, IL, increased by 35 percent from 1982.

I hope that H.R. 5400 will commend itself to this committee and to the Congress as an approach to the problem which deserves consideration.

There is no reliable data which will tell us the total annual cost of medical practice. Including the cost of defensive medical procedures, it appears to be well in excess of $20 billion.

Congressman Porter has asked the General Accounting Office to develop more reliable cost estimates. We do know that there is a great waste as well as great inequity in the present system. At a time when Congress and the public are greatly concerned about containing health care costs, this one element of cost would apparently merit congressional attention.

Mr. Chairman and Mr. Moore, I thank you for the opportunity to appear here today.

Chairman JACOBS. Thank you, sir.
Mr. Goldbeck.

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

Mr. GOLDBECK. Thank you, Mr. Chairman.

It is a pleasure to be with you. I am delighted to see the committee exercising leadership in this area, and want to thank the two of you, and Dick Gephardt particularly, for the work you have done.

It is indeed the general rule of thumb out in the communities around the country that the Congress will not have the guts to take on this issue because the Congress has too many lawyers to be willing to take on lawyers. I think it is delightful to see you are willing to put it on the table and deal with it forcefully.

I will try hard not to be presumptuous about our facts, or arrogant about the absence of those others. The basic simple point is that the system, as it exists now, does not work. It does not protect the patient adequately; it does not stop malpractice; it does not reward malpractice either intelligently or uniformly. It is a system, however well-intended, that is in failure.

The vast majority of the economic problems we are dealing with have absolutely nothing to do with whether a physician malpracticed, or any other medical provider, for that matter. The problem is also going to grow if you choose to do nothing about it. Forty percent of the American workforce today is 40 years of age or older. Combine that with its chronicity in degenerative diseases to the influx of new technology, the cost pressures and systemic approaches that provide incentives to do less, the false expectations of the American public about the miracles and myths of medicine and its omnipotence, the fact that we are approaching an era when finally, for the first time, the public will have comparative physician and hospital information. Together, these mean all the more that the opportunity for finding out what has gone wrong or presuming to think that something has gone wrong will clearly grow.

The current system serves virtually no one. It is very important that it be understood that it hurts people. The fact that defensive medicine is an economic problem pales in consideration beside the simple fact that everything done unnecessarily for defensive purposes is by definition bad medicine. It is medicine that was practiced not for curative or preventive reasons, but for economic protection, however understandable that may be. The attempt to get the States to act on their own has failed.

The bill that is before us has many things to commend it, albeit it raises questions. We don't know the impact on the volume of cases, and therefore on the aggregate dollars expended. I would hope that if the Congress was to pass this bill, it would include the opportunity for any effective State program that used another approach. Certainly, the Hawaii model is one that deserves consideration, and perhaps also the Indiana model.

I don't know whether you are giving out dollars today for knowing the Indiana system rather than for being a speedy witness, but let the record state that the Indiana system is doing a lot of interesting things with its 50-percent surcharge on the malpractice

system as its methodology for funding the State program. And just to cite one example, nationally an ob-gyn physician pays between $30,000 and $50,000 per year in premiums. In New York, it is upward of $80,000 per year. In Indiana, it is $3,500 per year plus $3,500 to the State fund. So even with the surcharge, it is a maximum of $7,000 per year.

That does not answer whether the cap is a good concept or bad concept. It clearly states it is an efficacious concept.

There are, it seems to me, four principles that should be embodied in whatever approach we adopt: One, to protect the patient victim. That does not mean protecting everybody who thinks they have a problem.

Two, to avoid direct access to the tort system while guaranteeing appeal access to the tort system.

Three, cut defensive medicine.

Four, to allow State flexibility where there is evidence of comparable effectiveness.

You might add a fifth to that, which is that pain and suffering ought not to be considered only in terms of replacement wages. There are other factors that can be built into the equation, just as they are built into workmen's compensation, where the only factor is not wage replacement. It is possible to do, and we can write in responsible protection for the Hoffritz's of the world.

Contrary to what you have heard, there is no economic incentive for bad quality care. Bad quality care produces more cases and ultimately is more costly to the employers or other payors. There are, however, incentives for less convenience and a breaking away from traditional patient-provider patterns and habits. As those break down, in the absence of a rational system of dealing with malpractice, the malpractice system will be the arena by which inconvenience is tested.

There is no indication that a managed care system in any way has to relate to less quality or that one cannot develop rational nonlitigious systems for quality control in managed care systems. By the process you designed, and through mandatory arbitrations, the poor and elderly, have a chance of getting something rather than today where they get virtually nothing.

This is not a bill that addresses economic redistribution in America, however significant that issue may be. It is not a bill that will stop discrimination against the poor. Indeed, being poor is probably inherently discriminatory and malpractice legislation will not resolve that.

Let me close with the thought that wasted medical care dollars are a far greater threat to access to and quality of care for our poor, our elderly, and ourselves, than anything negative which might result from addressing the malpractice system.

You and we are faced with three choices: a no-fault system, an arbitration system, or the status quo. The latter is the worst possible choice. Some combination of the other two probably has the greatest opportunity for producing a compassionate, ethical, and economically rational result.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

On behalf of the members of the WBGH, it is my pleasure to accept your invitation to comment upon H.R. 5400, The Alternative Medical Liability Act. You are to be commended for taking on this complex and costly issue.

Members of the Washington Business Group on Health purchase the medical care benefits for some 50,000,000 employees, retirees, and dependents. Added to these costs are contributions to Medicare, disability, sick pay, corporate medical departments and a vast array of non-insured health programs. You can easily see that we appreciate the medical care cost problem, and for that reason have an investment in alleviating the cost pressures intertwined with medical malpractice.

Medical malpractice has been a gnawing problem eating up valuable health care resources and intensifying the practice of defensive medicine. We welcome a legislative proposal that strives to expedite the granting of awards to victims, reduce the practice of defensive medicine, and moderate the size of awards and frequency of litigation. There is no rational defense for the current tort system that regards attorneys more than victims and penalizes providers of good and bad quality medicine indiscriminately. The incentives for lawyers and doctors alike are perverse; yielding inequities, injustices, and inefficiency. The time for action is now.

I do not come here to blame. As a representative of 200 major corporations, I recognize the prevalence of this problem and the need for proactive proposals, not finger pointing. Culpability is shared by all parties in this debate. Reform, in fact, can be a positive manifestation of purchasers and providers collaborating in order to achieve a more rational and cost-effective health care system. Business welcomes this opportunity to stand along side physicians and hospitals in condemnation of our tort system that yields only 28 cents of every dollar to the victim of a compensable act. In fact, great progress could be made if payers and providers became more cooperative in their efforts to bring about progressive change for our nation's health care delivery system.

There can be no question but that this piece of legislation's attempt to squelch the predominance of defensive medicine practiced in America is a positive development for all concerned. If 70 percent of all tests can be attributed to defensive medicine, then a moderation in that practice style will yield dramatic medical care savings. Even if the percentage of tests attributed to defensive medicine were reduced by half, the need to stop dependency on the tort system is compelling. The no-fault approach raises one major question that only experience will answer. Today, only a small fraction of known medically compensable events are even brought to litigation. Of those, only one in five result in an award. The no-fault system would encourage many more cases. We do not know if the total of more smaller cases will affect the savings achieved by reducing the few giant awards. Furthermore, patients are still provided the option of seeking legal redress through the conventional tort system. It is obviously not known how many patients will elect this option. These unanswered questions call for caution with respect to the drafting of the bill and its implementation.

I am not sanguine that this legislation will provide the catalyst for unilateral state action. However, we currently have the leadership of a few states—most notably Hawaii and Wisconsin—from which to take our cues. The WBGH does not endorse federal legislation that merely usurps state initiatives and imposes one template to be replicated nationwide. The Hawaii arbitration model, though not framed in the context of Moore-Gephardt, does offer one noteworthy example of an operating and efficacious state system. It seems a bit premature to assume that the unknown features of H.R. 5400—i.e., the volume of claims that will be generated—are better on paper than a state system that is working. If the Secretary of the Department of Health and Human Services is given the discretion to approve state malpractice programs based on the guidelines set forth in H.R. 5400, that discretion should extend to retaining effective state programs that do not comply. The same "waiver" approach ought to be made available for new models that states would propose as long as they prove to be at least as cost efficacious as the no-fault system. This bill is an outgrowth of a conceptual no-fault model that lacks real-world evidence. Let us not be so bold as to presume that a working state system should be scrapped or retooled to conform with an untried federal model.

My previous comments notwithstanding, Representatives Moore and Gephardt are to be commended for authoring this timely legislation. Giving states an incentive to establish malpractice guidelines for all payers is greatly appreciated by the business community. We would hope that all states would respond to the legislation so that the alternative of a federal program only affecting federal patients will not be the

end result. The 1987 date for federal implementation is sufficient time for states to comply.

H.R. 5400 grapples with a troublesome problem at a time when solutions are needed. Thank you for demonstrating leadership on this issue, and thank you for soliciting the opinions of the Washington Business Group on Health.

Chairman JACOBS. Thank you.

Ms. Lanam.

STATEMENT OF LINDA L. LANAM, EXECUTIVE WASHINGTON REPRESENTATIVE, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Ms. LANAM. Mr. Chairman, Congressman Moore, I am Linda Lanam, executive Washington representative for Blue Cross and Blue Shield Association.

On behalf of our 96 member plans, I am pleased to have the opportunity to present our views on the reform of the medical malpractice liability system. We believe that consideration of this issue is timely, and we are pleased that Congressmen Moore and Gephardt have stimulated new debate by introducing the Alternative Medical Liability Act, H.R. 5400.

As a major payor of health care costs, we recognize that malpractice insurance premiums and the practice of what is referred to as defensive medicine contribute significantly to the continuing increase in those costs.

There appears to be a general perception that, with regard to medical malpractice claims, the current tort liability system is not equitable in practice or in results. A 1976 medical insurance feasibility study, sponsored by the California Medical Association, found that, while almost 5 percent of hospitalized patients suffered some adverse outcome which could be argued to be malpractice, only about 17 percent of those patients would probably receive any compensation in a fault-based system.

Another survey by the Rand Corp., under contract with the Health Care Financing Administration, found that of all patients nationwide who filed malpractice claims in 1976, only 51 percent received any compensation. There may be several reasons for this. As noted earlier, some patients are dissuaded from getting into the system because of its adversarial nature and its often lengthy delays in payment. These delays have been compounded by the complexity of causes and treatment of illnesses and injuries which make the determination of actual negligence increasingly difficult.

It should also be noted that even when patients prevail, there is wide variation in the size of awards handed down by juries, even for substantially similar injuries. In addition, since the litigation is generally handled on a contingent fee basis, as much as 30 percent to 50 percent of those awards go to legal expenses rather than to the injured patients.

A nonadversarial system does have the potential for greater equity to injured parties. First, every patient who could establish that an illness or injury was incurred as a result of treatment by a provider could be compensated. This even-handed approach would include patients with illnesses or injuries not due to negligence, such as infections which occur in spite of stringent infection control procedures. Second, such an alternative system could reduce

the time required to determine the amount of compensation to be awarded by eliminating the need to litigate to find fault.

We do have some concern about the equity of certain specific aspects of the alternative system which would be imposed under H.R. 5400. If a State does not enact its own malpractice statute covering all patients by January 1, 1987, it would then be subject to a residual Federal system covering only patients whose care is paid in whole or part through Federal sources.

Patients subject to the Federal system would be eligible to receive an amount determined to fairly reflect their net economic loss resulting from the illness or injury and the reasonable expenses of collecting the benefits. They would generally not have access to the tort system to recover for pain and suffering. Conversely, patients whose care is not paid from Federal sources would not have access to the benefits of the alternative system.

Second, patients covered under either the State or Federal program would not receive compensation for pain and suffering unless there were some related net economic loss. A patient's net economic loss, other than payment for medical care, would be primarily based on the net loss of employment income. Equitable determination of this amount could be problematic because different persons have different patterns of lifetime earnings. Determination could be particularly difficult under the Federal system which would apply only to recipients of benefits under medicare, medicaid, FEHBP, CHAMPUS, and CHAMPVA. Many of these are people without wages or salary; for example, the aged or disabled or children.

Finally, the decision to make an offer to pay compensation benefits to an injured party under H.R. 5400 remains with the provider. Therefore, the ability of an eligible patient to participate in the alternative liability system will be dependent on a provider's analysis of whether it is economically better to settle or let the patient sue.

The alternative system contemplated under H.R. 5400 has the potential to dramatically reduce that portion of malpractice costs which is presently attributable to the financing of litigation. Also, because the compensation provided under H.R. 5400 does not include any benefits for noneconomic detriment, more commonly referred to as pain and suffering, the amount of each individual settlement should be less than under the tort system.

On the other hand, as has been pointed out, this system could also increase the number of injured persons who receive compensation, since recovery is no longer limited to those who can prove fault on the part of the provider.

H.R. 5400 would clearly cut total health care costs if it reduced the practice of defensive medicine. Since there would be no independent finding of fault required in the compensation process contemplated under this bill, providers arguably would have less incentive to practice defensive medicine as protection against malpractice claims. The right test at the right time for the right reason is the goal of quality medical care, and it is to be hoped that reducing the pressure of possible malpractice litigation will foster that goal.

We believe that the majority of health care providers deliver quality care, and will continue to provide such care regardless of

what system of determining malpractice liability is applied. Under the tort system, however, those providers who might provide substandard care may be deterred from doing so by the specter of lengthy and costly court proceedings, and because those found at fault are subject to both adverse publicity and increased malpractice premiums. H.R. 5400 does recognize this and would provide for some additional protections aimed at substandard care by subjecting providers to the tort system when the injury is alleged to be intentional or it results in wrongful death.

In summary, as with any proposals for such comprehensive reform, the full effect of a nonadversarial liability system will be clear only when it is operating. We believe that such an approach, as contemplated in H.R. 5400, should be carefully examined and possibly implemented in a limited area on an experimental basis. A detailed evaluation of its effects would provide valuable insight. We stand ready to assist the Congress in its further consideration of this topic.

[The prepared statement follows:]

STATEMENT OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION, PRESENTED BY LINDA L. LANAM, EXECUTIVE WASHINGTON REPRESENTATIVE

Mr. Chairman and Members of the Subcommittee, I am Linda L. Lanam, Executive Washington Representative for the Blue Cross and Blue Shield Associaiton. On behalf of our 96 member Plans, I am pleased to have the opportunity to present our views on the reform of the medical malpractice liability system. We believe that consideration of this issue is timely and we are pleased that Congressmen Moore and Gephardt have stimulated new debate by introducing "The Alternative Medical Liability Act," H.R. 5400.

H.R. 5400 is intended to deal primarily with the costs of the current malpractice system which are borne by hospitals and doctors and, ultimately, translated into higher health care costs. The bill would create a model federal malpractice system under which providers would have a period of up to six months to make an offer of compensation to an injured patient. This compensation would reflect the patient's "net economic loss," including the cost of related medical treatment, rehabilitation expenses and lost employment income. This compensation system would replace the tort system except in cases of intentional injury or wrongful death. States could enact their own malpractice laws covering all patients or, by 1987, the federal system would be implemented applying only to patients covered under federal programs.

Our comments are offered from the perspective of a participant in the health care financing system and not from any particular expertise on the subject of medical malpractice. However, as a major payer of health care costs, we recognize that malpractice insurance premiums and the practice of what is referred to as "defense medicine" contribute signficantly to the continuing increase in those costs.

Because malpractice costs are subsumed in a provider's total charges, we do not have an exact estimate of their total impact, However, in 1983 alone, doctors and hospitals paid approximately $2.5 billion in malpractice insurance premiums. The California Medical Association estimates that this adds, on the average, $5 to the cost of every patient hospital day and between $3 and $4 to the cost of every physician visit. Total premiums for physicians more than doubled between 1982 and 1983. The American Medical Association [AMA] estimates that the practice of "defensive medicine" costs as much as $15.1 billion annually. This estimate is based on the results of their own surveys which show that at least three out of four doctors acknowledged ordering more X-rays and tests than were medically necessary in order to provide better defenses against malpractice suits.

The current malpractice claims structure relies on the tort liability system. The adversarial nature of this system, its cost and the length of time required before a resolution is reached, have been criticized for discouraging the pursuit of valid claims. The tort system often does produce large awards to those litigants who are successful. The mean malpractice settlement in 1982 was $962,258. Many others, however, may receive nothing in compensation because they cannot afford to participate in the "lawsuit lottery."

A number of experts in the field, including members of the 1973 HEW Secretary's Commission on Medical Malpractice, have suggested consideration of alternatives to or alterations in the tort system. These include the voluntary or mandatory use of arbitration or claims screening panels prior to, or instead of, litigation; the appointment of additional judges in areas with large backlogs of cases to expedite the trial of malpractice cases; and increased peer review and quality of care standards. All of these options, however, would retain the current concept of a third-party determination of fault for treatment-related illness or injury as the basis of any compensation to an injured party.

The development of "no-fault" statutes governing automobile accidents and the generally accepted application of the same sort of concept to industrial injuries through the worker's compensation laws have now led to consideration of a type of "no-fault" system for treatment-related illnesses and injuries. This is generally the approach embodied in H.R. 5400.

We would compliment Congressmen Moore and Gephardt for introducing H.R. 5400, which we believe makes a major contribution to congressional debate on this topic. There are many complex issues involved in such an effort to improve the process of resolving malpractice claims, and we would suggest that you focus on three key criteria for evaluating any malpractice liability system: equity, cost, and quality of care.

EQUITY

There appears to be a general perception that, with regard to medical malpractice claims, the current tort liability system is not equitable in practice or in results. A 1976 Medical Insurance Feasibility Study, sponsored by the California Medical Association, found that, while almost 5% of hospitalized patients suffered some "adverse outcome" which could be argued to be malpractice, only about 17% of those patients would probably receive any compensation in a fault-basis system. Another survey by the Rand Corporation under contract with the Health Care Financing Administration, found that of all patients nationwide who filed malpractice claims in 1976, only 51% received any compensation. There may be several reasons for this. As noted earlier, some patients are dissuaded from getting into the system because of its adversarial nature and its often lengthy delays in payment. These delays have been compounded by the complexity of causes and treatment of illnesses and injuries which make the determination of actual negligence increasingly difficult. It should also be noted that even when patients prevail, there is wide variation in the size of awards handed down by juries, even for sustantially similar injuries. In addition, since the litigation is generally handled on a contingent fee basis, as much as 30% to 50% of those awards go to legal expenses rather than to the injured patients.

A non-adversarial system does have the potential for greater equity to injured parties. First, every patient who could establish that an illness or injury was incurred as a result of treatment by a provider could be compensated. This even-handed approach would include patients with illnesses or injuries not due to negligence, such as infections which occur in spite of stringent infection-control procedures. Second, such an alternative system could reduce the time required to determine the amount of compensation to be awarded by eliminating the need to litigate to find "fault." Providers would no longer have any incentive to delay court proceedings or present extensive opposing testimony nor would patients have to wait for a backlog of other court cases to be resolved before having a hearing. H.R. 5400 would provide for the speedy settlement and payment of claims by requiring that time limits be placed on the provider's offer of compensation and allowing settlements under $5000 to be agreed to without court reviews.

We do have some concern about the equity of certain specific aspects of the alternative system which would be imposed under H.R. 5400.

First, the proposal would create a dual system which would make the processes and remedies available to patients dependent on how the cost of their care is reimbursed. If a state does not enact its own malpractice statute covering all patients by January 1, 1987, it would then be subject to a residual federal system covering only patients whose care is paid in whole or part through federal sources. Patients subject to the federal system would be eligible to receive an amount determined to fairly reflect their "net economic loss" resulting from the illness or injury and the reasonable expenses of collecting the benefits. They would generally not have access to the tort system to recover for "pain and suffering." Conversely, patients whose care is not paid from federal sources would not have access to the benefits of the alternative system.

Second, patients covered under either the state or federal program would not receive compensation for "pain and suffering," unless there were some related "net economic loss." A patient's "net economic loss", other than payment for medical care, would be primarily based on the net loss of employment income. Equitable determination of this amount could be problematic because different persons have different patterns of lifetime earnings. Determination could be particularly difficult under the federal system which would apply only to recipients of benefits under Medicare, Medicaid, FEHBP, CHAMPUS, and CHAMPVA. Many of these are people without wages or salary, for example, the aged or disabled or children.

Finally, the decision to make an offer to pay compensation benefits to an injured party under H.R. 5400 remains with the provider. Therefore, the ability of an eligible patient to participate in the alternative liability system will be dependent on a provider's analysis of whether it is economically better to settle or let the patient sue. In the end, some patients will continue to be frozen out of either system.

COSTS

The alternative system contemplated under H.R. 5400 has the potential to dramactically reduce that portion of malpractice costs which is presently attributable to the financing of litigation. Also because the compensation provided under H.R. 5400 does not include any benefits for "noneconomic detriment," more commonly referred to as "pain and suffering," the amount of each individual settlement should be less than under the tort system. On the other hand, this system could also increase the number of injured persons who receive compensation, since recovery is no longer limited to those who can prove fault on the part of the provider. If the proposed new system does reduce all those costs not related to the economic loss of injured patients and those reductions are enough offset the increase in patients compensated, then the result will be cost-effective. It is important to note that both the automobile no-fault systems and the workers' compensation systems have seen significant increases in costs over their years of operation.

H.R. 5400 would clearly cut total health care costs if it reduced the practice of "defensive medicine." Since there would be no independent finding of "fault" required in the compensation process contemplated under this bill, providers arguably would have less incentive to practice defensive medicine as protection against malpractice claims. The right test at the right time for the right reason is the goal of quality medical care and it is to be hoped that reducing the pressure of possible malpractice litigation will foster that goal.

The bill proposes an "assigned claims plan" to assure the availability of funds to cover the inability of any provider or malpractice insurer to pay the promised compensation. The expenses of this plan are to be assessed against participating providers and insurers, thus introducing an additional cost into the system which will have to be offset by other savings.

QUALITY

We believe that the majority of health care providers deliver quality care, and will continue to provide such care regardless of what system of determining malpractice liability is applied. Under the tort system, however, those providers who might provide substandard care may be deterred from doing so by the specter of lengthy and costly court proceedings, and because those found at fault are subject to both adverse publicity and increased malpractice premiums. H.R. 5400 does recognize this and would provide for some additional protections aimed at substandard care by subjecting providers to the tort system when the injury is alleged to be intentional or it results in wrongful death.

SUMMARY AND CONCIUSION

In summary, we believe that H.R. 5400 will be a catalyst for congressional consideration of the substantial impact of the malpractice system on the equity, cost and quality of health care. Congressmen Moore and Gephardt, along with this Committee, have performed a valuable service for health care consumers, providers and payers by adding these issues to the congressional agenda.

As with any proposals for such comprehensive reform, the full effect of a nonadversarial liability system will be clear only when it is in operation. We believe that such an approach, as contemplated in H.R. 5400, should be carefully examined and possibly implemented in a limited area on an experimental basis. A detailed evaluation of its effects, would provide valuable insight. We stand ready to assist the Congress in its further consideration of this topic.

Chairman JACOBS. Thank you for your contribution.

Mr. Moore.

Mr. MOORE. Thank you very much. I thank all three of you for being here. I think you bring businesses viewpoint to the problem. That is one of the major concerns we have.

Mr. Goldbeck, your comments in particular offer something that has caused us to be disturbed. This shows the value of having a hearing on such a piece of legislation. Your idea on page 3 of applying a waiver approach to new models that states may come up with that are at least as good as this model is a broadening of what we have in the bill.

On page 26 of H.R. 5400, it says:

> In a state which has an alternative law which the Secretary of HHS determines substantially meets the requirements of this section, then the model law doesn't go into effect.

But you are offering a much better way to approach that. That caught my interest and is something that we will certainly consider in redrafting of this legislation.,

I thank you for that, and I thank all three of you for your testimony.

Chairman JACOBS. Mr. Goldbeck, I keep being rather parochial about this and asking about my State. You have bolstered my curiosity about the positions of the panelists. I don't have a dollar riding on this. Anything relating to Indiana involves corn, in one way or another, usually.

But if you were writing a Federal inducement statute, would you be intrigued, guided, whatever, by the system we have in Indiana?

Mr. GOLDBECK. Yes, I would be intrigued and clearly guided. I am not sure I would arbitrarily take it and put it in effect. I think the concept of a screening panel is essential, albeit not adequate, because there are other States that have produced no results with that system.

I think the concept of the surcharge as a methodology for paying a State fund is a very good one to explore—preferable, probably, to a single Federal fund, although if you can't get States to move, it may be useful to hold that out there as a club.

I think we are long past the time of waiting for volunteerism on the part of the States. As I am sure you recall when Senator Kennedy was trying to push this issue in 1976, the States came forth with pleas of how they would have it resolved within 3 years. And, much to their amazement and everybody else's, he said OK, and I think we have all suffered for at least another 8 years because of that.

The cap, obviously, raises some questions regardless of its constitutionality. The question is whether it works well, not only from an economic standpoint but also whether it produces the adequate degree of equity for those truly injured in the system.

I don't think there is any question but that we need an arbitration approach. Whether that is conjunctive with a no-fault approach or separate, I suspect we just don't have the evidence yet.

One of the reasons we posited in our statement that we ought to let other approaches be experimented with is that I don't think we know what the impact will be, and it is foolish to hold out a singu-

lar approach. Indiana has something on the books. Let's watch it for a few years.

Chairman JACOBS. Mr. Williams, Ms. Lanam, have either of you an opinion with respect to the question I asked?

Ms. LANAM. I think I would offer only one comment, since I am originally from Indiana—but my most recent experience was as deputy insurance commissioner in Pennsylvania where we have an alternative malpractice system. We finance catastrophic loss through a surcharge, and the fund, as in Indiana, which pays judgments over a certain amount so that the cost of malpractice insurance to physicians is mitigated by the carve-out portion. And I think the various systems that actually did come from the malpractice crisis in the early seventies show that if given a chance, States can act and take action that will reflect their needs.

And if this legislation can be drafted to encourage them, one, to do something, but two, to take into account their own both judicial system and medical system, it would be useful.

Chairman JACOBS. Mr. Williams?

Mr. WILLIAMS. Mr. Chairman, I don't know enough about the Indiana system to make any useful comment. However——

Chairman JACOBS. It is just southeast of you, from Chicago.

Mr. WILLIAMS. Yes, it is near enough. But I guess I have been persuaded that there will be a diversity of approaches that will inevitably be taken by all the States. And there needs to be some Federal model, some leadership in this area, which would, whether it embodies a carrot-and-stick approach or not, be something that would serve as a guide for State legislation—not to preempt it but to encourage it.

Chairman JACOBS. Well, thank you.

Mr. GOLDBECK. I would like to make one comment, Mr. Chairman, from the perspective of a patient. This is not my classic constituency but it is a major concern. The pressures from physicians, workmen's comp, and lawyers weigh heavily on patients in the absence of a rational malpractice system. I can cite this best in the personal example I have, because I know my facts are correct.

I was 24 years old, a basketball coach, and I got a leg torn up in an accident. The workmen's comp in New York advised me to claim lifetime disability. I was 24, and I was offered a blank check for the rest of my life. That would have paid me then a higher salary than I was earning by working. I might add, there was absolutely nothing in any record before or since that suggests one has to be able to walk around to coach. But that was what I was offered.

When I was going through the medical process of recovering, during one of the operations I incurred a staph infection in the hospital. I was visited by two separate lawyers whom I had never heard of—not at my suggestion, not at my physician's suggestion—who somehow or other heard there was somebody lying in a bed who had a problem. They said all I had to do was file a case and I would never have to work again for the rest of my life. They could guarantee me at least $1 million, because I was going to lose my ability to coach again.

That type of pressure is not an isolated circumstance. It is driven by a system out of control where the patient is the least considered

person, in reality. We need the Congress to exercise the kind of leadership that is inherent in the approaches you are at least willing to try through this legislation.

Thank you very much.

Chairman JACOBS. Thank you.

We thank the panel very much for your contribution to the record.

The next panel is the National Council of Community Hospitals, John S. Hoff, counsel; and the Hospital Corporation of America, Robert E. Pierson, vice president, Parthenon Insurance.

STATEMENT OF JOHN S. HOFF, COUNSEL, NATIONAL COUNCIL OF COMMUNITY HOSPITALS

Mr. HOFF. Thank you, Mr. Chairman.

I am John Hoff. I am here on behalf of the National Council of Community Hospitals.

The bill before you focuses attention on a problem that is obvious from today's witnesses and must be addressed, and we believe it proposes a creative solution. The testimony today has been interesting because it has shown there is no one—at least no one who has appeared here—who is satisfied with the current method for compensating patients who are the victims of medical malpractice. The one possible exception is the Trial Lawyers Association, and they are unhappy with the insurance companies. The only other exceptions are those participants who wish that more people were able to enjoy the fun and games of litigation, a result which we submit would only make the present problem worse.

The present adversarial system, the testimony has shown, is deficient in a number of respects. It draws off far too much money in transaction costs. It takes too long. It requires juries and judges to make judgments on highly complex questions of causation which are beyond their normal experience. Recoveries are based on emotion. Recoveries are fortuitous; the system pays a very vew claimants what, as Mr. Goldbeck suggested, are exaggerated amounts—and fails to pay anything to most victims, as even the trial lawyers' statistics show.

On the other hand, H.R. 5400 would encourage payment of economic loss to more people, more quickly. It would rechannel money now spent on transaction costs and payment to a few winners of the litigation lottery to provide payments to more patients. And it does so most importantly without abandoning a fault-based system.

Providers should not be required to pay where there is not fault. We cannot afford an across-the-board, no-fault system.

The bill does not impose a Federal solution, but suggests an idea for State consideration. We believe, on the basis of the ferment going on in the States now, that a number of States will, in fact, be interested.

I have been interested this morning listening to the testimony to assess the criticisms that are leveled at the bill. Most of the criticisms are, I believe, based on a misunderstanding of what is inevitably a complex piece of legislation.

The major criticism, which was made primarily at the beginning of the session, was a fear that a provider could make a tender offer

to a patient that would be inadequate. By definition, however, a tender cannot be adequate. To qualify for the protections of the bill, a tender must be not for a dollar amount but be a commitment to pay certain defined elements of damages.

There will always be disputes on whether a particular item occurring after the commitment has been made is recoverable under that commitment, but we believe that that will be a very small percentage of the cases and a much simpler litigation, if it goes to that, than is the current litigation process.

The physician witnesses had a number of suggestions. They objected, for instance, to the joinder of parties permitted by the bill. That, however, is the case now. Defendants can be brought in in any litigation under the present system, and the bill would not change that.

They also referred to a need to define "sickness." The genius of the approach in the bill is, in fact, that this does not need to be defined—and it can't be defined. The definition is left to the individual case when the provider makes its decision whether or not to make a tender.

Finally, if the test of the bill is whether or not Jascha Heifetz would be recompensed for the loss of three fingers, it must be noted that loss of his fingers would trigger generous benefits.

Thank you.

[The prepared statement follows:]

STATEMENT OF NATIONAL COUNCIL OF COMMUNITY HOSPITALS, PRESENTED BY JOHN S. HOFF, COUNSEL

My name is John Hoff. I am a lawyer, practicing in Washington, D.C. My address is 1000 Thomas Jefferson Street, N.W., Washington, D.C., and my telephone number is (202) 342-5514. I appear today on behalf of the National Council of Community Hospitals, an organization of approximately 110 community hospitals in 32 states around the country, which provide approximately 50,000 beds. NCCH and its members are committed to the formulation and support of reforms in the health care delivery system. For that reason NCCH supports H.R. 5400.

In summary, NCCH supports the bill because the present malpractice system is expensive and counterproductive; it provides inflated recoveries to a few patients, but only after delay and great expense, and does not provide fair compensation to many others. H.R. 5400 would use money now spent in transaction costs and in paying noneconomic recoveries to a few patients to provide fair payment of economic losses to more patients, and do so quickly and without the expense and trauma of litigation. It is fairer both to patients and to providers.

Compensation for patients who suffer from malpractice is of great concern to hospitals. They are concerned both because of their dedication to the well-being of their patients and because of the increasing costs they incur when untoward events occur in a hospital. A generation ago hospitals were immune from tort suits under the doctrine of charitable immunity. With that doctrine effectively eliminated, hospitals pay for tort recoveries and malpractice insurance. Premiums for malpractice insurance have continually increased. There was a malpractice crisis in the mid-1970s during which premiums increased rapidly and insurance was difficult to obtain. Malpractice premiums have continued to increase since then, and there are indications that a new malpractice crisis is now brewing.

The malpractice crisis cannot be addressed in isolation. It is a consequence of the tort system by which we determine who will be compensated for what injuries, and how much they will receive.

The present tort system is a cumbersome, expensive, and inefficient method of determining compensation. The system promises large and even windfall gains for a few victims totally without regard to what they need for compensation, but denies fair payment for most victims.

Recovery is allowed not only to compensate the injured patient for his real economic loss but also to pay him for his "pain and suffering," and various other theo-

ries of noneconomic loss, and to extract punitive damages from the defendant. These elements of damages are entirely subjective, and the amount of verdicts awarded are thus matters largely within the discretion of the jury. The emotional appeal of the plaintiff to the jury is a critical element in determining which patients recover, and how much they can recover.

In addition, plaintiffs can in some instances collect twice for the same damage—from the tortfeasor and from collateral sources.

Recovery depends upon proof of negligence—a concept difficult to establish in as inexact an activity as medical care. Juries do not have personal experience in diagnosing disease or performing surgery. The reasonable man, therefore, must be guided by expert witnesses. The result is trial by phalanxes of experts who evaluate a physician's decisions with the wisdom provided by hindsight.

The system holds out the promise of very large recoveries, far in excess of real economic loss. Plaintiffs are encouraged to go for the big win. But very few actually collect on the promise. And those who do typically must litigate for five to seven years to do so, a process which not only delays receipt of compensation but is often traumatic to the patient who must undergo it. And the litigation process is expensive—to plaintiffs, defendants, and to society as a whole.

The present system is particularly unresponsive to the needs of Medicare beneficiaries. They file malpractice claims at a rate roughly one-fourth of the rate at which patients under 65 years of age do. The fact that earning capacity, and thus the potential recovery for economic loss, declines for most persons over age 65 partially explains this discrepancy. There are other factors as well. Medicare beneficiaries are less likely to want to become involved in the judicial system. They are less willing to engage in an adversarial dispute with the physician who is treating them; they perceive a more immediate and continuing need for his care, and fear they may not be able to find another physician. Their shorter life expectancy does not permit them the luxury of waiting for the outcome of years of litigation.

The tort system is not only a flawed way of paying patients who are the victims of malpractice. It also has adverse effects on the health care system. Most importantly, the fear of large recoveries and attendant publicity forces physicians to engage in defensive medicine, which the American Medical Association estimates costs $15 billion a year in added physician costs alone, as well as subjecting patients to added risks and inconvenience. The fear of malpractice forces physicians to abandon high risk areas of practice. And the cost of the malpractice premiums leads to increases in physician fees.

The risk of a physician being sued is increasing rapidly. Recent data collected by the AMA, for instance, reveals that the percentage of physicians against whom a claim is brought has almost tripled in the period 1978–83: from 3.3 to 8.0 per cost. And when a physician is sued, despite doing what he believes is his best on behalf of his patient, he is often emotionally debilitated.

H.R. 5400 promises to extricate patients and providers from the tentacles of the present system. It would redirect money now wasted on transactional costs and expended in windfall recoveries for a few plaintiffs who are successful in the lottery of litigation towards fair compensation for more victims of malpractice.

The bill provides incentives to providers to make a commitment to pay patients who are the victims of malpractice the real economic loss suffered by them. If the provider wishes not to be subjected to litigation potentially resulting in judgments for pain and suffering and punitive damages, it must make a commitment within six months of any malpractice to pay the victim's real economic loss. The payments must be made for the patient's losses as they accrue—for items such as continued medical and hospital care, counseling, and adapting his home and car.

The bill provides incentives for providers to unearth any malpractice and to inform patients of it, since they must make a commitment to pay economic loss within 180 days of the act which could give rise to a claim if they wish to avoid liability for noneconomic damages.

The bill makes it unnecessary for patients to determine which of various participants in their care is responsible for a bad result. It relieves the patient of that dispute and forces the various providers to resolve that issue among themselves.

The patient thus receives the assurance of fair payment that will make him economically whole, of receiving that payment quickly, and of avoiding the time, trauma, and risk of litigation. Money now spent to pay nonecomonic damages to a few will be used to provide economic recovery for more patients. By providing the means to avoid the spectacular verdict, the bill will tend to reduce the amount of defensive medicine which is practiced, resulting in lower health care costs and improved quality of care.

These benefits will be particularly attractive to the elderly, who are concerned more about recovering their health and adapting to any infirmity than they are in pursuing for many years a lawsuit against their doctor in the hope they may eventually win a judgment which includes elements on noneconomic damages.

Most importantly, while the bill provides for quicker recovery, it is not a no-fault system. It maintains fault as a critical element in determining recovery. It does not require providers to make the commitment to pay economic loss whenever there is an untoward event but only when they believe that the unsatisfactory result of health care was the result of negligence. Because of the inevitability of death and disease, and because of the difficulties in determining causation in health care, it would be inapporpriate and vastly expensive to require payment in all cases where the result of health care was unsatisfactory. The bill properly avoids that.

There is a question whether malpractice is a proper concern for the federal government. NCCH believes, however, that H.R. 5400 strikes the right balance in this regard. It sets out an idea for consideration by the States, but does not require them to enact it, and does not impose any penalty if they do not do so. However, if a State chooses not to institute a program along the lines of H.R. 5400, the federal government has an interest in providing a fairer, more effective, and more efficient system for compensating beneficiaries of the programs funded by it for any malpractice they may suffer. This is particularly so to the extent that doing so reduces defensive medicine and thus constrains health care costs. The bill correctly threads the line between States' interests and the federal government's concern for its own health programs. We believe, in addition, that Congressional consideration of the ideas incorporated in H.R. 5400 will encourage States to consider similar reforms of their tort systems even before the legislation is enacted, and certainly after. While we are concerned about federal involvement in health care, we believe that with the leadership of the sponsors of this proposal a well-crafted bill can be enacted, a bill that will demonstrate that federal involvement in health care can be constructive.

Chairman JACOBS. Mr. Pierson. I should say the Parthenon Insurance Group.

STATEMENT OF ROBERT E. PIERSON, VICE PRESIDENT, PARTHENON INSURANCE CO., HOSPITAL CORP. OF AMERICA

SUMMARY

1. The current medical malpractice system neither determines fault nor compensates adequately. The effort through the tort system to find fault has become tortuous and costly for both litigant and defendant. Most victims of medical mishap receive little if any compensation while a very few receive extreme and unreasonable levels of compensation.

2. HCA's experience indicates that the number of claims is increasing as is the average settlement per claim. Over 60% of claims however are ultimately either dropped by the claimant or are resolved in favor of the defendant. Since 1977, seven cases have accounted for 67.5% of compensation paid by Parthenon.

3. The indirect emphasis the current malpractice system places on defensive medicine may have seriously affected costs, quality and access. Under the current system, restructured cost incentives under both Medicare's PPS and private capitation could force providers to choose between those procedures that are appropriate and beneficial and those that are necessary for a potential legal defense.

4. Providers are and will be increasingly forced in some situations to eliminate those services representing potential high liability—i.e., obstetrics.

5. The challenge of medical malpractice liability reform is to encourage continued improvement in provider risk management and quality assurance by holding them appropriately responsible for their actions while at the same time, discouraging behavior inconsistent with the provision of high quality, cost effective health care.

6. H.R. 5400 will lessen the pressure on physicians to practice medicine based on the requirements of the courtroom rather than the needs of the patient by broadening the distribution of compensation to many more claimants; resulting in more equitable compensation; and resulting in the bulk of malpractice premiums going to the victims of medical mishaps and not to the legal process.

Mr. PIERSON. I am Robert Pierson. I am vice president of Parthenon Insurance Co., a wholly owned subsidiary of Hospital Corp. of America in Nashville, TN. Parthenon insures 227 owned and managed hospitals in the areas of property, workers' compensation, and

medical malpractice and general liability. Parthenon also insures on a very limited basis approximately 700 hospital-based physicians. Parthenon operates in over 40 States and its premium volume for 1984 will be upward of $60 million.

My remarks today will focus on two areas in which this committee has expressed interest and requested comment: the compelling need for reform of the current medical malpractice system, and the manner in which that reform should best be accomplished with specific reference to H.R. 5400, the Alternative Medical Liability Act. In so doing, I will draw upon Parthenon and HCA's experience to the extent possible, recognizing that hard data is generally lacking in this area.

THE CURRENT SITUATION IN MEDICAL MALPRACTICE LIABILITY

The medical malpractice system as currently conceived requires that a determination of fault be rendered by the judicial system before compensation can be awarded to the victim of a medical mishap. But because the practice of modern medicine has become characterized by complex interrelationships of individuals and technologies applied to the treatment of diseases and illnesses—which in and of themselves are unpredictable and complex—the search for fault is more often than not elusive.

In addition, because of this elusiveness, the effort to find fault has become torturous and costly for both litigant and defendant. The end result is that most victims of unintended medical mishap fall by the wayside and receive little if nothing in the way of compensation. The few who are ultimately successful often receive extreme and unreasonable compensation predicated, it would seem, upon their ability to survive the rigors of the process and strike an emotional chord with a jury. These windfalls, in turn, attract frivolous claimants who seek to take advantage of the system in hope of gain. The end result is a system which is both manifestly unfair in terms of its outcomes and exceedingly costly.

These criticisms are borne out by data drawn from our own experience: From 1978 to 1982, HCA's medical malpractice claims increased by 50 percent on a bed-adjusted basis. For the same period, HCA's total medical malpractice claims payments increased by 297 percent on a bed-adjusted basis. We assume that for the period 1982 to the present, for which claims are only now maturing, that these trends will hold up.

Independent actuaries estimate an ultimate total payment of $27 million for HCA's 1984 malpractice claims.

Based on current claims experience, we anticipate in 1984 the lowest payment per case, Tennessee, to be $9,500, with the highest, Florida, being $23,800.

In approximately 60 percent of the cases filed, claimants were unsuccessful in pursuing their claims.

Since its inception in 1977, seven cases accounted for 67.5 percent of total payments made by Parthenon on behalf of HCA hospitals.

A breakdown of these latter seven cases is, I believe, particularly instructive. Five of the cases involved infants and children under the age of 3. One case was relatively straightforward, involving a gentleman of 53 years of age who was inadequately monitored in a

recovery room and suffered cardiac arrest, resulting in severe brain damage.

The final case is already well known by this committee and involved a gentleman in Florida who drank and dove—dove, that is, into a shallow pond and broke his neck. Notwithstanding the preponderance of evidence which showed that the man owed his life to the quick actions of hospital personnel, a jury awarded a $10 million malpractice judgment against the hospital which was subsequently reduced to $6.3 million by the judge.

These specific cases and the overall distribution of claims and settlements are, we believe, indicative of the outcome of the medical malpractice system in this country.

The cost of maintaining the system is similarly skewed. Attorneys' fees, whether on behalf of defendant or plaintiff, consume the bulk of the funds which are committed to the system through medical malpractice premiums. Our own preliminary analysis would seem to confirm that at least two-thirds of every premium dollar goes toward fees for lawyers and expert witnesses along with other transaction costs, leaving only a third at best for the ostensible beneficiary of this process—the injured patient.

The end result, therefore, is a medical malpractice system which fails on both tests—it neither determines fault nor compensates victims adequately.

On the surface, we would argue that the manifest failure to produce a just and reasonable outcome would constitute grounds for reform. It is, however, the indirect effects of the system on health care costs and quality in general which demand legislative action in this area.

INDIRECT IMPACT OF THE CURRENT MEDICAL MALPRACTICE SYSTEM

In order to defend themselves against spurious claims and the vagaries of the system that I have enumerated above, physicians order unnecessary tests and procedures. While the extent of such defensive medicine is difficult to document, we would not quarrel with the AMA's estimate that such practices exceed $15 billion in annual costs. In the past, hospitals have often complied with such defensive practices which were generally reimbursable by third parties, including medicare.

With the implementation of prospective payment and capitation systems, medicare, various States, and private employers have introduced incentives for hospitals to reduce unnecessary procedures and costs. How these contradictory incentives will ultimately resolve themselves is still unclear. There is a significant danger that resolution could come at the expense of overall quality and access as hospitals and physicians are forced to make tradeoffs between therapies or patients.

Faced with not only limited funds but also the current liability system, providers will increasingly be faced with choices between therapies which are pain reducing or otherwise beneficial and appropriate for the patient and therapies or tests which may be necessary to a legal defense. The payment systems simply do not allow for both.

An equally undesirable alternative would be to eliminate those services which are directed at higher risk patients—higher risk in the sense of liability. A case in point is reflected in the increasing difficulty HCA is experiencing in recruiting physicians interested in obstetrical practices in geographical locations where such services are not currently being provided.

We recognize that there exists a counterargument to the criticisms that I have just leveled at the malpractice system. That is, the threat of malpractice liability results in improved quality control on the part of physician and hospital. To a certain degree, this counterargument has some validity. In response to increased vulnerability, hospitals have increased their sophistication as risk managers.

Parthenon Insurance, in fact, was created in the aftermath of the malpractice crises of the midseventies. It has enabled HCA to bring to the hospital environment state of the art quality control and risk management techniques.

The monitoring of physician performance in terms of quality is of the highest priority to the organized medical staffs of our hospitals. We anticipate that this emphasis on quality control on the part of HCA and other providers will be further enhanced by the concern that many have of the effect of prospective payment systems on physician and hospital behavior.

The challenge, we believe, is to modify the current liability system in a manner which continues to hold providers appropriately responsible for their actions, but at the same time not result in provider behavior inconsistent with the provision of high-quality, cost-effective health care.

H.R. 5400—THE ALTERNATIVE MEDICAL LIABILITY ACT

It is our opinion that H.R. 5400 represents an important contribution to meeting this challenge by: Encouraging providers to come to a settlement outside of the legal system—the bill eases the question of blame and broadens the distribution of compensation to many more claimants; limiting settlement to net economic loss—H.R. 5400 ensures that truly equitable settlements are made to victims irrespective of their ability to emotionally move a jury; streamlining the process and encouraging providers to settle quickly. The bill would result in the bulk of malpractice premium dollars going where they should: To the victims of medical mishaps and not to the legal process.

The overall result, in our opinion, will be to lessen the pressure on physicians to practice medicine based on the requirements of the courtroom rather than the needs of the patient.

We recognize that the introduction of H.R. 5400 is only the beginning of the effort to reform a system demonstrably in great need of such reform. As in all issues which raise equity concerns, we expect disagreement to exist.

Mr. Moore and Mr. Gephardt are to be commended for introducing their proposal which makes a major contribution at balancing the needs of potential victims and the requirements of providers, and in doing so, establish appropriate parameters for those disagreements to occur within.

Chairman JACOBS. Mr. Moore.

Mr. MOORE. Thank you, Mr. Chairman.

I appreciate the testimony of both gentlemen. For purposes of the record, I would like to identify Mr. Hoff as more than counsel for the National Council of Community Hospitals. He has been privately working with Mr. Gephardt and myself, for the 1-year period we have been drafting this bill. And so to him goes a great deal of thanks, as he has been very intimately involved in working with Professor O'Connell, my colleague Mr. Gephardt, and myself, in bringing this legislation into bill form.

Mr. Pierson, your company has been very active in terms of risk management, something I think is a very important thing in holding down health care costs and malpractice claims.

Is it your experience that hospitals are, in fact, or have they ever withdrawn privileges of practice to a physician who is found, through the risk management programs, to be a poor risk, or someone running the possibility of malpractice claims?

Mr. PIERSON. Yes. Our company has developed a quality assurance program which evaluates the effectiveness of what has in the past been known as peer review within the hospital. All HCA hospitals require in their bylaws that physicians be periodically reviewed for performance through a system. When our corporate level risk managers visit a hospital, they review the review process to make sure the physicians who are questionable are being adequately evaluated.

Physicians have been forced from our hospital staffs because of less than adequate performance.

Mr. MOORE. Mr. Pierson, you have a unique point of view to bring to the hearings, coming from a hospital company, as well as an insurance company.

What opinion might you have from your experience, both as to whether or not we will see an increase in money being paid out, or claims being settled by virtue of the proposal we are discussing in this bill, as opposed to the existing tort system?

Mr. PIERSON. Based on the seven cases referenced in my testimony that represent a substantial amount of payments we have made, it is my opinion that it would reduce the individual payments being made.

Those cases all involved serious injuries where long-time care of the injured party would be required, so there are still going to be sizable payments. But you would not see the $10 million windfall judgment. In that case, for example, to take care of the injured party—and this is just an estimate—I think you could spend $1 million in what is known as a structured settlement to lawyers and take care of that individual for his medical needs and the other needs that he has for the rest of his life.

Mr. MOORE. That was a point of concern, as you noticed from several of the witnesses. They questioned whether in fact there would be increased settlements.

In a hypothetical case, let's assume—this is just a rough assumption, the numbers being hypothetical—let's assume there is $100 million being paid out this year in the tort system for medical malpractice, let's say, to 100 people.

Could you give us your opinion as to what you could see paid out to people in 1985 under a system like we are proposing? Would you have more money paid to more people, or less money paid to more people, or the same?

Mr. PIERSON. In my opinion, definitely it would be less.

Mr. MOORE. Less money paid out?

Mr. PIERSON. Significantly less.

Mr. MOORE. Would you be paying it to more people?

Mr. PIERSON. More people.

Mr. MOORE. So, in your opinion, and the experience of your insurance company and your corporation, what you are telling us is that you will probably pay out less money than you are paying now, but you will spread that over more plaintiffs?

Mr. PIERSON. That is true.

Mr. MOORE. Thank you both for your testimony.

Chairman JACOBS. Let me thank the panel for its contribution. Thank you for coming in.

The final testimony will be given by Thomas O. Pyle from the Harvard Community Health Plan, president, Group Health Association of America, and chairman, Controlled Risk Insurance Co.

STATEMENT OF THOMAS O. PYLE, PRESIDENT, HARVARD COMMUNITY HEALTH PLAN; ALSO, PRESIDENT, GROUP HEALTH ASSOCIATION OF AMERICA, AND CHAIRMAN, CONTROLLED RISK INSURANCE CO.

Mr. PYLE. Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Pyle, welcome to the committee. Proceed in your own fashion. You appear to be the caboose.

Mr. PYLE. Mr. Chairman, Mr. Moore, distinguished staff: My name is Thomas Pyle. I want to thank you for the opportunity to talk with you this afternoon about the difficult problem of providing fair compensation to patients who are injured while receiving treatment in the health care system.

You have already reviewed what I do. I would just mention, the Harvard Community Health Plan is a health maintenance organization in Boston serving 168,000 members. I appreciate your taking me last, since we opened our sixth health center this morning, and I had to be there for the ribbon cutting.

There is also a correction in my testimony. Our trade association is a trade association of closed panel health maintenance organizations rather than a closed panel trade association.

Let me describe the Controlled Risk Insurance Co., which has relevance to what we are talking about today. It is a captive insurance company owned by 12 institutions affiliated with Harvard Medical School. The company was formed during the malpractice crisis of 1976 on the theory that we were already paying for the cost of quality in the care we provide and should be getting the benefits in our malpractice insurance premiums.

We currently insure these shareholders' institutions and about 4,500 physicians affiliated with them. There are about 4,000 beds involved, and insurance covers both malpractice and general liability.

It is ironic, incidentally, that one of my cofounders was Thomas Dudley Cabot, a former business and government leader, and well-known philanthropist and hospital trustee who got involved in this because of his enormous interest in no-fault insurance for malpractice. He saw our company as an alternative because he didn't believe at that time in Massachusetts we could get a no-fault system going.

So no-fault is kind of embedded in our organization. I am sure you have heard many others today who can speak with much more authority and experience than I about the shortcomings of the current system. However, I would like to note it collects billions of dollars, and about two-thirds of this goes to various legal and administrative expenses, which doesn't seem to be terribly effective.

About one-third goes, on the average, to those who are arguably injured. And this takes about 7 years in distribution. Frequently the wrong people get these awards in the wrong amounts and it is after a bruising and acrimonious ordeal. I would like to concentrate for a moment on that.

As a provider of health care, this current system really is a disaster, because it creates the need for an extensive process of litigation, discovery, adversarial roles which not only are bad in and of themselves, but ultimately begin to affect the care process and physician-patient relationship. Potential plaintiffs don't wish to become involved in this, and particularly the elderly and the poor often forego, as best we can tell, their rights under this system.

And so we find people not suing. Now the statistics on this issue as you might expect are very difficult to get. But many knowledgeable people in the field feel that fewer than 25 percent of the patients negligently injured end up filing some sort of claim. It is also a traumatic experience for the physician because it results in a highly organized and very public endeavor designed to prove that he is incompetent. The process takes a heavy toll in terms of self-esteem, reputation and perhaps even future income.

I might add in this regard that it often has no relationship to the quality of the physician or to the actual malpractice that may or may not have occurred. On one case we saw a physician that we not only believed to be innocent but was judged to be innocent in court, offer to put $50,000 of his own money into a settlement in order to avoid the possibility of public trial. So it is a very traumatic experience for the physician to get into. It is often argued that there is a benefit in this because it has some effect on quality. I can assure you that there is no relationship to quality in the current malpractice system. In fact, it is almost dangerous because there is a perception in the public's eye that those negligent or incompetent physicians come to a public scrutiny through the current system.

I do not believe that that occurs. I think we do have quality problems in our current system but those aren't solved at all through the malpractice system. In fact, the very large awards mean that everyone is covered under insurance, and there is no personal penalty for a very large award being given.

Most important, the process puts the physician in an adversarial role vis-a-vis his patient and this disrupts the physician-patient relationship which can be very bad for the patient and for the physi-

cian. The current system really makes it necessary for the physician and for the organization that is involved in medical care to deny any error and in effect to sever any kind of relationship with the patient.

It is extremely distressing to me personally as president of a large health care organization that the current legal situation makes it an extremely difficult thing for me to come forward and admit when we have made a mistake, because the penalty on doing that is very high. The proposed legislation shifts this posture, and encourages physicians to reach out if negligence has occurred.

I would like to comment here that negligence is rather a poor word. The best professionals make mistakes, although there is a great attempt to deny it in our society. Surely, no thoughtful individual doubts this. Watch any athletic contest—golf, basketball, sailing, football—read the FAA record, talk to pilots or recall any political campaign. I represent an insurer who insures physicians who are arguably the best physicians in the world or at least among those. And I can assure you that mistakes occur in this group.

Not all of what we consider to be negligence is the result of the few incompetent practitioners. It is a part of medical practice. And there needs to be a way of dealing with it which doesn't encourage the kind of denial that goes on today because of the adversary system. I don't think it would be appropriate for me to comment on the technicalities of this law since I am not knowledgeable about tort law. But I can assure you as someone who works in this field both on the insurance side and also as a head of a large health care organization, that I think the proposed system would be better for injured patients and would result if fairer compensation.

Thank you.

[The prepared statement follows:]

STATEMENT OF THOMAS O. PYLE, PRESIDENT, HARVARD COMMUNITY HEALTH PLAN

Mr. Chairman, members of the subcommittee, my name is Thomas Pyle and I want to thank you for the opportunity to talk with you this moring about the very difficult question of how to provide fair compensation to patients who are injured while receiving treatment in the health care system. I am the President of the Harvard Community Health Plan, which is an HMO located in Boston serving 168,000 members. I am also serving as President of the Group Health Association of America which is the national trade association closed panel of Health Maintenance Organizations. And relevant to the topic being considered today, I am Chairman of Controlled Risk Insurance Company which is a "captive" insurance company owned by the twelve institutions which comprise the Harvard affiliated medical system. The company was formed during the so-called malpractice crisis in 1976 and currently insures the shareholder institutions and 4,500 physicians affiliated with those institutions.

There are many others who I am sure can speak with much more authority and experience than I about the shortcomings of the current medical malpractice compensation system in this country. However, it seems to me that a system which:

collects billions of dollars in premiums
spends over two thirds of the money in various legal and administrative expenses
pays the remaining one third on average seven years after the injury
frequently to the wrong people in the wrong amount
after a bruising and acrimonious ordeal for all involved is a system crying out for improvement.

From my perspective, principally as a provider of health care and to a lesser extent as a malpractice insurer, the salient feature of the current system is the misery inflicted on both the patients and their physicians. It is not easy for a patient who thinks he or she has been injured through negligence to file a suit. Pa-

tients typically like, respect and indeed feel dependent upon their physician. The adversarial role inherent in litigation is unnatural to most patients, particularly the elderly and the poor. The mechanics of the legal process, including depositions and testimony, frequently are also very intimidating. Finally, when the patient does file the suit the unpleasant experience seems to drag on interminably. Various studies have shown that nationally the median malpractice claims dollar is paid to the patient seven years after the date of injury. Once again, the elderly and the poor are the least able to bear these long delays awaiting compensation.

A final important point regarding consumers is that most patients who are negligently injured while receiving health care do not sue and therefore do not receive any compensation. Precise statistics on this phenomenon are of necessity difficult to collect since there is no accurate way to measure the total number of injuries and unfortunate medical outcomes which are due to negligence. However, various studies and the opinion of people knowledgeable in the field hold that fewer than 25% of the patients negligently injured file a claim. The reasons for this relatively low claim yield are not fully understood. The point I made earlier must surely be part of the reason, along with ignorance of both the cause of the bad outcome and of the legal process.

Being sued is also an extremely traumatic experience for the physician. After all, he is now caught up in a highly organized and very public endeavor designed to prove that he is incompetent. The process takes its heavy toll in terms of self-esteem, reputation and perhaps even future income. Also, administrative interviews and meetings, depositions and trials which are frequently measured in weeks add up to a huge amount of lost time. But perhaps most important, the process puts the physician in an adversarial role vis-a-vis his patient. This stance is contrary to everything which is embodied in the concept of the physician-patient relationship. Indeed, not only is the physician unable to reach out and attempt to provide remediation for the injured patient, the realities of the legal system and insurance policies require him to deny any error and in effect sever all relationships with the patient. Such a response does not truly serve the interest of either the patient or his physician.

I am not an expert in or even very knowledgeable about tort law. Therefore, it would not be appropriate for me to comment upon the technicalities and nuances contained in H.R. 5400, the Alternative Medical Liability Act. However it appears to me that the approach embodied in the bill would alleviate a great many of the obvious failings of the current system. It should result in many more injured patients being fairly compensated much faster with much less destructive acrimony.

Chairman JACOBS. Thank you.

Mr. Moore.

Mr. MOORE. Mr. Chairman, I want to thank Mr. Pyle for being with us and very much appreciate his practical point of view he brings from the insurance field.

I want to say in conclusion, Mr. Chairman, I think the hearing has been immensely helpful in the sense of bringing out the pro's and con's of the legislation and to assist perhaps in redrafting of it next year. I want to thank you again for having taken time, in the very busy closing hours of this Congress, to hold this hearing and to be here presiding.

Chairman JACOBS. We thank the witness, Mr. Pyle, for your contribution to the record. Don't be surprised if we call on you again. We are not going to legislate on this matter, I should say, before midnight, tonight. I would imagine, as Mr. Moore says, there will be a fathering interest in the subject, certainly until the next Congress. And the manner around here is to gather evidence all over again if a new Congress begins. So we may call on you again.

Mr. PYLE. Thank you very much.

Chairman JACOBS. Thank you very kindly.

This concludes the hearings.

[Whereupon, at 2:40 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF ROBERT B. HELMS, ACTING ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Department appreciates the opportunity to submit these general comments concerning the matter of medical professional liability. At this time we are reserving the right to comment specifically on H.R. 5400, the "Alternative Medical Liability Act," until we have fully analyzed the proposed legislation.

Without question, the increased scope of medical liability is a serious problem faced by the country's medical professionals and hospitals. Ten years ago, the situation was of such magnitude that the former Department of Health, Education and Welfare conducted the first major study of the matter and issued a landmark report identifying important trends affecting professional liability.

Many of those trends have continued, not only in medical malpractice but in many other areas as well. Although unheard of just a few years ago, our society now witnesses the suing of teachers for "educational malpractice," doctors countersuing lawyers for legal malpractice, and even clergy being held liable for the results of their spirtual counseling. One of the burgeoning issues in Congress today concerns compensation legislation, covering such matters as adverse reactions from immunization, radiation, industrial pollution and occupational hazards (e.g., black lung). The growing problem of product liability prompted the Commerce Department in 1976 to establish a task force to examine its impact on the economy.

It is widely believed that perceived losses or grievances require court redress whenever possible, sometimes regardless of merit or fault. For example, Federal District Courts from the New York-New Jersey-Connecticut region have reported this summer that their civil case loads have increased as much as 140 percent since 1978. In metropolitan Detroit, medical malpractice claims jumped by 64 percent between 1979 and 1981.

There is no question that health care providers, seeking to protect themselves, have increasingly adopted the tactic of defensive medicine, ordering tests and procedures ordinarily not necessary to patient care but which could serve as defenses in any subsequent malpractice allegation.

Certainly, in seeking to be a prudent steward of taxpayer dollars, the Federal Government must be concerned about the impact on costs of defensive medicine and malpractice damage awards. Yet even though claims may be increasing, there is no particular body of evidence to suggest that actual medical malpractice is being committed with any greater level of frequency than it ever was. In testimony before the Senate Labor and Human Resources Subcommittee on Health in 1975, Dr. James F. Dickson, then Acting Deputy Assistant Secretary for Health, observed that "what appears to be occurring in medical malpractice is not an increase in the number of iatrogenic injuries, but rather an increase in the number of injured people who file claims." A 1976 patient attitude survey by the well known medical journal Medical Economics revealed that while the proportion of patients who would consider suing a doctor for malpractice remained the same as in 1963, the current problem was that more patients actually followed through with litigation. At the same time, by a 52 percent to 48 percent margin, more patients saw the average doctor as "dedicated to helping people" rather than those who believe doctors view medicine "chiefly as a business." This compares to a 1969 survey in which 86 percent held to the first view with only 14 percent subscribing to the latter view.

Advances in medical technology, though perhaps accompanied by greater risks, offer more hope for better results. Yet together with improved medical knowledge comes a heightened expectation by patients for guaranteed results. Imperfect results or unmet expectations, particularly in high-risk medical specialties such as orthopedics, obstetrics and surgery, may lead to allegations of malpractice. A statistical study of closed claims released by the National Association of Insurance Commissioners (NAIC) during 1976 and 1977 confirms the tendency for patients to sue the most qualified, board-certified specialists, whose practices are the most lucrative and whose insurance coverage is the most comprehensive, rather than the so-called "bad doctor." That is, there may be a predilection to single out those perceived to be in the best position to pay.

In response to the difficult situation of ten years ago the medical profession, cooperating with the insurance industry, the legal profession and state legislatures, sought ways to alleviate the malpractice problem. Beginning with the Indiana Patients Compensation Act of April 1975, nearly three-fourths of the states adopted some form of professional liability reform legislation. In some instances they included requirements for pre-trial voluntary screening panels in an attempt to weed out frivolous suits, or encouraged mandatory arbitration to avoid adversarial litigation. Other reforms placed limits on attorney contingency fees in an effort to reduce exor-

bitant claims. In some states, groups of doctors organized "captive" insurance companies, a way of self-insuring in the absence of commercial insurance availability.

While these reforms were widely hailed, they did not eliminate the practice of defensive medicine and in many respects exposure to medical liability continues unabated. As the American Bar Association's Commission on Medical Professional Liability stated in April 1976, at the height of the state tort reform movement, "it is (our) tentative view that for the foreseeable future changes in the tort law system are not likely to meet the underlying problems. . ."

The Insurance Services Office (ISO) is a research and statistical organization which the insurance industry relies upon for data in determining rates for various types of insurance. In the February 1976 edition of MLC Commentary, the publication of the Medical Liability Commission (established at the suggestion of the 1973 H.E.W. Secretary's Commission on Medical Malpractice), an ISO official explained that predictability and past experience are at the heart of rate-making and the prediction of future experience. Jurisprudential trends expanding the scope of liability and rendering the risk actuarially unstable leave insurors with no choice but to withdraw from the market or impose massive rate increases, according to ISO.

Courts must be considered as a prime factor in this regard. Patients may allege malpractice, and attorneys may take their cases to court, but ultimately judges and juries must determine whether there is fault or not, and under what standard. As the judicial system has continuously expanded the scope and meaning of medical liability, predictability in insurance has been uprooted. Health care providers, unsure about what new theory or precedent of liability may be established by a court tomorrow, have understandably engaged in defensive medical practice.

The chief trend in jurisprudential activity has been to shift the locus of medical risk-bearing away from the patient toward the provider. For example:

The 1974 Washington State case, *Helling* vs. *Carey*, held that even though the defendant doctors committed no malpractice under established standards of reasonable and proper care, the fact that the patient sustained an injury meant that the doctors were liable because, given their incomes and insurance coverage, they were better able to sustain the loss than the plaintiff.

Arthur H. Bernstein, a legal consultant to the American Hospital Association (AHA) and medical jurisprudence writer for Hospitals, the journal of the AHA, has written that "the judicial contribution to the law of malpractice has enlarged the risk assumed by providers. New principles of law will be adopted only if the appellate court justices concur. To a considerable degree, the increased exposure of physicians to liability . . . has resulted from changes in the law. Money-seeking patients, clever attorneys, and overly generous juries could not have raised the cost of malpractice to its present level without cooperation from the courts." (Bernstein, Hospitals, July 1, 1976).

Dr. Dickson's 1975 Senate testimony for the Department stated that "we do not agree with those who view increases in the number of malpractice claims as a sign of a deteriorating level in the quality of medical care . . . The trend in American society is toward litigation for all injuries."

A 1976 report entitled "How Lawyers Handle Medical Malpractice Cases," issued under the auspices of the National Center for Health Services Research (NCHSR), noted that "There seems to be no doubt from the data . . . that the fault principle is the key element in keeping down the level of malpractice claims and the numbers of cases in which money is paid out to injured patients. Its removal could well result in a vast increase in claims handled by the insurance companies and by lawyers as well." Citing previous evidence contained in the famous "Westat Report," used extensively in the Department's study of medical malpractice, the NCHSR paper inferred that because the scope of actionability is increased, the grounds for filing a malpractice suit have been broadened, meaning increased liability for providers. The Westat report confirmed through its survey of experienced trial lawyers that they (lawyers) felt that only one-third of the malpractice cases they handled involved true malpractice.

In his paper, "The Malpractice Equation: A Conceptual Tool for Analyzing the Malpractice Problem," prepared in 1975 for New York State's special advisory panel on malpractice, Dr. Eli Bernzweig, who was executive director of the HEW Secretary's Commission on Medical Malpractice, noted the trend of the courts in establishing liability without fault as a serious problem. He cited the 1967 California Supreme Court case of *Clark* vs. *Gibbons*, which openly said that losses from ordinary medical accidents should be shifted "to the parties best able to protect against them through insurance" and that courts must abandon the "largely fictitious" search for fault. Dr. Bernzweig asserted that "however laudable the social objectives of courts who view the problem in this manner, our existing liability insurance system was

never intended to compensate all unexplained injuries arising out of treatment, and continued judicial sanction of liability-without-fault to achieve this purpose is certain to cause the collapse of the liability insurance mechanism as we know it."

In 1981, the Michigan Supreme Court ruled that no doctor may countersue a lawyer for bringing a frivolous malpractice court action. A plaintiff attorney owes no duty to a defendant, the court said. He need only serve his client's interests, including the pursuit of nonmeritorious suits, if he wants to do so. Rather than reduce the scope of liability, the court in this instance expanded the opprotunity for more cases to be filed.

Portland, Ore., attorney Ridgway K. Foley, writing in the March 1983 edition of the medical journal Private Practice, noted that "(E)very time legal doctrine obviates the necessity of proof of negligence, of fault, of causation, of damages, or of responsibility, it exhibits a built-in bias in favor of the supposed victim and against the professional defending the charge."

In short, the issue is not merely to design a new form of compensation system which will permit patients to collect faster or to obtain reparations merely because of an untoward result. A thorough and effective approach to the problem must also address the matter of the expanded scope of professional liability. In that regard, even though prior legislation may be found wanting, the ultimate answer, in our view, lies in attaining adjustments and reforms in tort law.

There are currently 3 components to a malpractice judgment: (1) medical and other direct costs; (2) lost current and future wages; and (3) compensation for pain and suffering. The last component is the largest part of most settlements. Proposed Federal legislation being considered by this Subcommittee would remove that portion but would likely induce an increased number of settlements.

Whether this type of approach will achieve the desired result is unclear. For the Medicare and Medicaid programs, for example, the first component—medical costs—is the relevant issue. Although the programs would recover the related medical payments they made on behalf of the patients receiving settlements, the increased number of settlements could result in increased malpractice premium costs to providers and, on balance, inreased costs to our programs. The recovered medical bills for Medicare and Medicaid patients would go largely to the programs. Many of our beneficiaries have little or no current or future wages on which to settle.

While the conventional tort liability system has been criticized for the manner in which it handles medical malpractice cases, a solution does not appear to rest with establishment of a no-fault alternative or some other form of automatic compensation system. Such arrangements may reduce rather than enhance incentives for high quality health care, especially if any injury is bound to be compensated for regardless of liability. By the same token, such alternative systems may actually drive up costs.

Even given the extraordinary expansion of the scope of liability in recent years, there are still cases filed and claims made which are unsuccessful. Removal of all doctrines of responsibility and liability could result in all iatrogenic injuries becoming eligible for reparations. Further, a financing mechanism for the payment of claims would be necessary. If operated by the government, medical risk-bearing would become spread among all taxpayers, rather than among all doctors and hospitals carrying insurance. Likewise, adoption of a no-fault or similar reparations system would likely require a fundamental re-evaluation of the role and status of health care professionals in our society in terms of whether they are practitioners of the healing arts, where results may be imperfect, or whether they are to be akin to bonded repairmen, whose work must be done right or else a reparations system will automatically proffer compensation.

In summary, we believe that tort reform may be the most promising response to the malpractice cost problem. Proposed Federal legislation appears to present a substantial likelihood of being counter-productive in this regard. While proposed Federal reforms may encourage speedier payment of claims, program costs may be increased rather than decreased. A Federal compensation system would also do little to reduce the scope of medical risk-bearing by providers and malpractice insurors, focusing instead on limiting the defenses providers might have should they fail to offer reparations to patients claiming iatrogenic injury.

AMERICAN DENTAL ASSOCIATION,
Washington, DC, July 13, 1984.

Hon. ANDREW JACOBS, Jr.,
Chairman, Subcommittee on Health,
Committee on Ways and Means,
Washington DC.

DEAR MR. JACOBS: The American Dental Association appreciates this opportunity to present its views on H.R. 5400, the malpractice reform bill introduced by Representatives W. Henson Moore (R-LA) and Richard A. Gephardt (D-MO). It is our belief that consideration of the malpractice issue is timely both for Congress and the dental profession.

Fifteen years ago, the dental profession faced a crisis situation where professional liability insurance was unavailable at reasonable cost in various parts of the nation, and where certain dental specialists were unable to obtain protection at any cost. In response to this situation, the American Dental Association developed a national insurance program which offered professional liability insurance in combination with other property and casualty coverages needed by most dental practitioners. This program, called the Professional Protector Plan, is now available in every state except California and has provided a stable source of malpractice insurance protection since 1970.

While the dental malpractice insurance situation has stabilized with respect to availability since the early 1970's, there are alarming trends of increasing incidents of malpractice, size of jury awards in dental cases, and of course, the resulting hikes in malpractice insurance premiums. Still, as a whole, most dentists in general practice who do not administer general anesthesia in their offices do not have difficulty in obtaining professional liability coverage, and premium levels are reasonable as compared to those paid by other health care professionals.

For the nearly five percent of dentists who do administer general amesthesia outside the hospital setting, annual malpractice premiums are approximately 10 times those paid by other practitioners. This category of dentists is primarily comprised of individuals performing oral surgery, which are typically called the most complex and risky cases. Coverage for these high risk professionals is still available, however, the costs of such coverage is rising significantly with a growing realization that fewer and fewer insurance companies are willing to accept these risks.

As you are aware, this proposed legislation would establish an optional federal alternative liability system based on prompt compensation for net economic loss as an alternative to resolving malpractice claims in the existing tort litigation process. Under the alternative system, health providers could limit potential liability by making offers to compensate injured patients for "net economic losses". Net economic losses would include medical expenses, rehabilitation costs, loss of employment income, and attorney fees. Patients could not recover amounts for pain and suffering, physical impairment, punitive damages, consortium or other general damages.

Once the provider offer is tendered, the patient would have to accept it except as to the amount or integrity of the offer. If the provider did not make an offer within an allocated time period, the patient would retain his right to proceed with a malpractice action under the present law. Initially the states would be encouraged to adopt alternative liability statutes based on the model federal standards. If a state failed to enact such a law prior to January 1, 1987, the federal system would become applicable to malpractice claims arising out of services rendered in medicare, medicaid, and other federal health programs.

First of all, the Association commends Representative Moore and Gephardt for their efforts in formulating a proposal aimed at improving the present expensive litigation-encouraging process of resolving malpractice claims. The dental profession especially appreciates the inclusion of "dentists" in the defintion of eligible health care providers who would be afforded the opportunity to participate if and when any alternative liability system came into actual practice.

As an alternative to the present, costly malpractice litigation system, the Moore-Gephardt proposal holds out the hope of greater equity to patients and health care providers; an improvement in the quality of care by alleviating the need for defensive practices; and a possible reduction in health care costs to consumers, health care providers, and the federal government.

Quite frankly, our main concern with the proposed system as outlined in H.R. 5400 is simply whether it will work if implemented? Will the prospect of limited liability be a sufficient inducement for providers to admit wrongdoing and make reasonable offers for net economic losses to injured patients? How would the implementation of such a system address the "defensive" practices resulting from causes

above and beyond the fear of potential malpractice liability? Would the alternative liability proposal result in a more cost efficient, less litigous manner of resolving malpractice claims or could it develop into a costlier proposition due to uncontrollable increases in malpractice claims without any actual reduction in the number of cases or amounts of awards litigated?

Mr. Chairman, the answers to these questions and other concerns raised about the actual impact of such a system are not answerable in committee hearings or the halls of Congress, but only through demonstrated workability of such a proposal, perhaps in several states and/or possibly through private contracting outside the tort system as was suggested by witnesses at a recent Senate hearing on malpractice. Besides providing a test mechanism for the alternative liability system, an incremental approach involving state statutes and/or private contract could focus on areas, such as California, New York, or Florida, and professional specialities, such as oral and maxillofacial surgeons, that have potentially more malpractice problems than other areas or specialty groups. In short, the present malpractice situation in our view is not a universal, nationwide problem. It lends itself more readily to solutions in the plural rather than to any single solution.

Another concern with H.R. 5400 is that it would result in a dual system of rights and remedies for patients based on how the cost of their care is reimbursed. Under federally funded programs, patients would be eligible, if the health care professional makes an offer of compensation, only for his net economic losses. On the other hand, non-federal patients would have open access to the tort system with recovery for "pain and suffering" as well as other damages. A related discriminatory aspect of the federal or state alternative liability system would be that patients who are unemployed, aged, disabled or children would be unduly limited in their potential recovery due to the definition of "net economic losses", with its emphasis on the net loss of employment income. A possible solution to this dilemma would be to establish an alternative method to determine the reasonable amount that could be recovered in such circumstances.

Another provision of H.R. 5400 that might affect the viability of the alternative liability system is the joinder of parties clause. This would permit a health care provider, in tendering a settlement, to join any person who is also potentially liable for the injury and who may benefit from foreclosure of action. While, in some instances, joined parties might be relieved to pay a share of compensation benefits, in other cases such parties would be bound without regard to possible constitutional rights to jury trial and due process. Such concerns actually extend to the entire alternative liability process itself as well as the joinder of parties provision. In either case, such legitimate considerations could be possibly ameliorated by explicit private contracts detailing the rights and remedies of all parties, patients, providers or others connected with the dispute.

Finally, the Association would recommend that the alternative liability system be perceived as one of many possible malpractice reform initiatives, including a reduction in the statute of limitations; placing limits or caps on compensation; binding arbitration; structured settlement; and a possible redefining of the standard of care. The Association and other health organizations in the private sector have also undertaken efforts to provide quality health care services and indirectly reduce the number of malpractice incidents. Such ADA programs include peer review and quality assurance; efforts to insure stronger licensing and credentialing standards, and sponsorship of loss prevention seminars.

Mr. Chairman, in summary, we reiterate our appreciation to Representatives Moore and Gephardt for introducing the alternative liability system legislation contained in H.R. 5400. We believe that the alternative liability proposal as outlined in H.R. 5400 should be carefully reviewed and proved effective in reducing the costs of malpractice in several states or by contract in the private sector before it is applied to nearly one third of the nation's patients who receive their care through federal health programs. We look foward to continue working with Representatives Moore and Gephardt, their staffs, and interested parties on developing possible, workable solutions to resolve the malpractice problem.

Sincerely

JAMES P. KERRIGAN, D.D.S.,
Chairman, Council on Legislation.

ASSOCIATED HEALTH SYSTEMS,
Phoenix, AZ, June 29, 1984.

Mr. JOHN J. SALMON,
Chief Counsel, Committee on Ways and Means,
U.S. House of Representatives,
Washington, DC.

DEAR MR. SALMON: I am writing with regard to the Subcommittee on Health's consideration of H.R. 5400 and the issue of medical liability. My experience as a physician, as a medical educator, as Assistant Secretary of Health (1971–73), and currently as President of Associated Health Systems has convinced me that the threat of malpractice litigation has undesireable effects on patterns and costs of medical care. While my Association has no stated position on this issue, I have a strong personal interest in the matter and have been a party to discussions of the solution proposed by Congressmen Moore and Gephardt on H.R. 5400 and other solutions.

I encourage your committee to seriously consider the merits of H.R. 5400, and take expeditious action in this area. As an alternative, or as a source of strengthening provisions to H.R. 5400, I am enclosing a brief personal paper on the issue of malpractice and the feasibility of using Professional Review Organizations (PRO's) standards to facilitate more reasonable determinations of "malpractice."

You may include this material in the record or use it in any way that is helpful. If I can be of personal assistance to the Committee or staff on this matter, please feel free to contact me.

Sincerely,

MERLIN K. DUVAL, M.D.,
President.

Enclosure.

POTENTIAL COST SAVINGS BY USING PRO NORMS AS A DEFENSE IN MALPRACTICE SUITS

SUMMARY

Costs of physicians' and hospital care are currently increased by the threat of malpractice suits in two ways. First, due to the number of suits and size of awards, premiums for malpractice insurance are very high, as much as 15–20 percent of the gross practice income of some professionals. These costs are passed on to public and private payers in higher prices. Second, the fear of malpractice suits prompts hospitals and physicians to practice "defensive medicine" by doing tests and procedures they consider unnecessary and over and above what reasonable norms of care would prescribe. These defensive medicine costs are very likely much higher than malpractice premium costs, and, of course, are passed on to the public and private payers.

Malpractice litigation and premiums may well increase as a result of DRG prospective payment to hospitals, and more awards may well be made. This is due to the financial incentives in DRG payment for hospitals and staff physicians to decrease services and length of stay. Under cost-reimbursement, the financial incentive is basically on the side of doing more. Attorneys might argue that since the DRG financial incentives favor doing less, more burden should be placed on the providers to prove in court they have done all that good medical care requires. Moreover, fear of such litigation could prompt physicians and hospitals to continue defensive medicine practices—in spite of DRG fiscal incentives to the contrary—and thwart some portion of possible DRG savings.

If PRO-established norms of care were used to decide malpractice cases, it would very likely reduce both premiums and defensive medicine costs. Such a policy could reduce the number of malpractice awards based on divergent and conflicting medical testimony, and it would reassure hospitals and physicians that they need not offer tests and procedures beyond these norms of care unless they believe it necessary for medical reasons.

BACKGROUND

The original PSRO legislation contained a provision that (1) protected PSRO staff and reviewing physicians from libel and other civil suits; and (2) offered protection to physicians and hospitals from malpractice liability so long as their actions were in compliance with norms of care applied by a PSRO in the area and carried out with "due care." (Sec. 1167(c) of the 1972 Social Security Amendments, P.L. 92-603.) This provision was included as Sec. 1157(c) in the revised Title XI, Part B, of the Social Security Act enacted in the Tax Equity and Fiscal Responsibility Act of 1982.

This provision has been used on a number of occasions in law suits affecting PSRO staff and physicians.

Whether Sec. 1167(c) has been used as a defense in malpractice litigation generally is not known. The provision includes ambiguous language which some argue vitiate its usefulness. In addition, since all of the country was not covered by PSROs, and since many PSRO's have never developed explicit norms of care for most areas of medical practice, the percentage of malpractice cases influenceable by the provision has been relatively low. Legal research on state malpractice cases in recent years would be helpful to evaluate the actual usefulness and problems of the existing provision.

Since PRO's will cover all areas of the country and review all Medicare inpatient cases/DRG's, there is great potential for them to affect malpractice litigation if the law encouraged or directed it.

HOW TO DO IT

There are three basic approaches to having PRO norms used in state courts to decide malpractice suits. One approach would rely on attorneys, judges, and juries to make greater and greater courtroom use of PRO norms of care as they are developed and as they are increasingly accepted as appropriate by health care professionals in the community.

A second approach would have the federal government offer state governments incentivies to amend their tort laws to establish PRO norms of care as an admissable, or a primary, or the singular criterion for deciding malpractice suites.

A third would preempt state law by prohibiting providers from being held civilly liable in federal or state courts if they were in compliance with PRO norms.

The first approach, if adopted, might be enhanced by federal actions to publicize the usefulness of PRO norms of care in court, commission legal studies, and pursue legal opinions that encourage both legal professionals and health care providers to use the norms.

The incentives approach would result in more rapid action, especially if model state legislation exists or could be designed by the Conference of State Legislators or other responsible groups. Incentives, such as increased Medicare malpractice cost payments, need to be explored with state legislators. Legal research could identify and evaluate model legislation already on the book in states or under discussion.

The preemption approach, which is the most intrusive into state affairs, could be accomplished with improvements in the provision in existing law to eliminate ambiguites. It would seem most justifiable to extend this protection only to physicians for their Medicare patients, and, perhaps, their Medicaid patients—since the federal government has, after all, set up PRO's to be its judge of quality care for these patients. The federal government might rely on the increasing acceptance or the incentives approach (above) to extend this protection, in time, to physicians and hospitals treating patients covered by private third-party payers.

Whichever approach is used would require amendments to the PRO law, and would require PRO's to move expeditiously to explicating norms of care in as many areas of practice/DRG's as possible. This may require additional funding for PRO's—from both public and private sources. Both government and private payers who contract with PRO's may find they save more on malpractice costs, however, than they spend on PRO's.

SOME PROBLEMS TO BE CONSIDERED

1. Conflicts-of-interest need to the thought through, since the physician community might be argued to have increased incentive to set PRO norms at low levels in order to minimize malpractice vulnerability.
2. Funding of more comprehensive PRO norms, which could be applied to care for all patients, must clearly be drawn from state and private sources as well as federal, and may take time to materialize.
3. Legislation preempting state tort law might be challenged as within the jurisdiction of the Judiciary Committee, especially if the preemption extended beyond Medicare and Medicaid beneficiaries.
4. Anti-trust issues are raised by the concept of norms of care that might influence patterns of practice so extensively that they standardize services and limit competition. It would be important to design federal or model state legislation so that it uses PRO norms only as criteria of malpractice—and not as criteria of consumer-preferred or even efficient practice.

STATEMENT OF ERIC J. OXFELD, MANAGER, HEALTH CARE AND EMPLOYEE BENEFITS, CHAMBER OF COMMERCE OF THE UNITED STATES

The Chamber of Commerce of the United States appreciates the opportunity to present our views on H.R. 5400 (Moore, R-La., and Gephardt, D-Mo.), the Alternative Medical Liability Act, medical malpractice liability generally, and defensive medicine. All of our members are employers, who finance nearly 60 percent of annual health care expenditures. Our members also include providers of health care services and equipment, and firms insuring health care costs.

While the Chamber has no position with respect to H.R. 5400, we remain committed to the goal of providing a quality health care system that also is cost-effective. The medical malpractice system is a significant contributor to the rising costs of health care. The Chamber is now exploring whether changes are needed to control malpractice costs, minimize the practice of "defensive medicine," and strike a fair balance between plaintiffs and defendants.

PROBLEM: RISING HEALTH COSTS

The rising cost of health care has become a major concern of all interested parties, including the business community and the federal government. Although many factors contribute to the cost increases, malpractice insurance and defensive medicine practices conservatively are estimated to be about 6 percent of the total health care bill. Changes to the medical malpractice system that reduce malpractice related expenses would aid efforts to contain health care costs.

A number of approaches to the malpractice issue currently are under consideration. In evaluating them, one must examine the need for action, the balance of equities among plaintiffs, defendants, and users of health care, and, if legislation is advisable, the level and extent of government involvement.

THE MEDICAL MALPRACTICE PROBLEM

Medical malpractice is a term used loosely to describe the common law tort system, as it applies to improper performance of professional duties by a physician or other provider of health services. An individual who is harmed by negligence in treatment may bring an action for damages, under rules developed primarily through decisional law and varying from state to state.

Most health care providers carry insurance against medical malpractice claims. Over the last decade, the cost of this insurance has risen steadily. The annual cost varies by geographic area and medical specialty. The upper extreme is over $80,000 for some obstetrician-gynecologists in New York. These costs are expected to rise considerably over the next two years.

The growing cost of malpractice insurance has a number of obvious consequences. Physicians are reluctant to practice specialties for which insurance is relatively expensive. In addition, consumers must pay more for health services, because malpractice insurance adds to overhead, and because practitioners are more likely to order precautionary tests or other procedures designed to protect against possible malpractice claims—so-called defensive medicine. The American Medical Association estimates that defensive medicine costs more than $15 billion a year.

It seems unlikely, with all the advances in medical treatment, that physicians have become more negligent in providing health care. What, then, has caused this problem? One reason may be that the delivery of health care has changed. For example, practitioners today may have less personal relationships with their patients, and it may be easier to sue a stranger. The growing trend toward specialization means that patients now consult a number of physicians rather than a trusted "family" doctor, and they may not have the opportunity to develop rapport. Furthermore, physicians themselves may be reluctant to develop close relationships with patients lest something they say be used against them later. Finally, the growth in popularity of health maintenance organizations (HMO's) and preferred provider organizations (PPO's) may mean that patients are relying less and less on one familiar practitioner.

Another reason may be that patients expect too much of our medical system. Medicine can be an inexact science. Human beings are unique, and individuals with identical symptoms may not respond the same way to a particular treatment. Americans are notoriously litigious, and may be inclined to sue when disappointed with the result of treatment. But the persistence of symptoms does not prove that a wrongful act was committed.

Publicity given to the issue also has played a part. Reports in the news media of large malpractice awards may encourage people to sue.

POSSIBLE RESPONSES TO PROBLEM

Proposals to address the medical malpractice problem have taken several forms.

1. Take no action. Some argue that no action is necessary because current economic trends will ameliorate the problem. The trend toward use of HMO's and other cost containment efforts has led to reduced use of hospitalization and length of stay. Because malpractice claims typically are associated with hospital treatment, the number of malpractice claims may decline accordingly. Furthermore, institution of the Diagnostic Related Group (DRG) prospective payment system for Medicare and Medicaid may cause providers to abandon defensive medicine practices out of economic necessity. In addition, malpractice insurers and physician organizations are taking steps to educate health care practitioners about how to avoid malpractice claims. A recent book entitled Malpractice: A Guide to the Legal Rights of Patients and Doctors, by Donald L. Flaster, M.D., L.L.B., contains a good discussion of how all concerned can avoid lawsuits.

On the other hand, some argue that the growth of the problem shows few signs of slowing down. Critics of the DRG system and alternative delivery systems argue that the very emphasis on cost reduction may lead to more claims, because patients may not receive all medically useful treatments or may be released from hospitals too soon.

Moreover, the development of large plaintiffs' law firms specializing in medical malpractice claims may be a force for additional malpractice litigation, and courts constantly seem to be expanding the grounds for action against physicians and their insurers.

2. Private contracts. One approach is to have patients agree to give up any right to sue, by contractual agreement. There are now firms marketing such contracts.

Private contracts have been criticized, however as possibly unconstitutional, and as unacceptable to patients. These points are fiercely debated. Some have suggested that acceptability to patients could be increased by including such agreements in HMO or PPO plans.

3. State tort reform. Many states have passed legislation to reduce, in varying ways, medical malpractice costs. Some have established caps on recovery for pain and suffering. Others have mandated the use of arbitration or other alternatives to filing suit.

Critics note that state responses also have varied in their effectiveness, in part because of differing judicial climates. And some states have taken no action, despite vigorous legislative efforts. Another criticism of a cap on pain and suffering is that it discriminates against young people, who would have relatively more pain and suffering over a lifetime than an older person.

4. Schedule of Benefits. An alternative to tort reform would be establishment of a new system using a schedule of benefits, payable on a no-fault basis, modeled on workers' compensation. Such a proposal was considered by the Florida legislature this year.

Workers' compensation programs pay benefits to workers whose injuries arise out of and in the course of employment, without regard to fault. Benefits, prescribed by statute, include full medical care and vocational rehabilitation, plus a percentage of wages while the individual is off work as a result of the injury. No compensation is paid for noneconomic losses, such as pain and suffering, nor are punitive damages considered. Employers are required to insure or self-insure workers' compensation risks, and enjoy immunity to tort liability for such injuries.

The Florida plan would have required all health care providers to carry "medical incident insurance. " When an "adverse medical incident" occurred, a claim would be filed with an administrative agency, which would award compensation at the rate prescribed for injured employees under the Florida workers' compensation law.

Supporters of this approach argue it is fairer than tort reform, because all individuals with the same injury would receive roughly equal compensation. Critics, however, believe it represents too radical a change from the tort system.

5. Federal malpractice settlement. H.R. 5400 and S. 2690 are intended to encourage prompt settlement of malpractice claims. Health care providers would be given six months following a malpractice claim to offer to pay all economic losses (primarily loss of earnings); in return, there would be no tort liability for pain and suffering and other intangible losses or punitive damages. Once such an offer is made, the claimant could litigate only the amount of economic losses, and no litigation would be required to prove "fault." If the provider fails to offer to pay economic losses, however, the claimant would have full rights to sue as under current law.

This legislation would apply to all federal programs (Medicare, Medicaid, and programs for veterans and federal civilian employees), or a state could cover all individuals by setting up its own program identical to the federal model or more stringent.

Critics of this approach have identified a number of problems with it, including the preemption of state law, the likelihood of two malpractice systems within one state, and the constitutionality of cutting off tort liability. Spokesmen for the plaintiffs' bar fear it would reduce safety incentives for health care practitioners. And representatives of organizations representing the elderly and the poor claim that it is discriminatory against retirees and others who are not working and therefore have little or no economic loss.

CONCLUSION

The sponsors of H.R. 5400 and S. 2460 are to be commended for drawing public attention to the medical malpractice problem and possible solutions to it. However, representatives of the medical and legal communities, insurers and employers, and consumers of health care services have raised serious questions and concerns about the malpractice situation, the need for action, and the form it should take. These concerns must be addressed, and the questions answered. The Chamber will be reviewing this issue in detail preparatory to developing policy. We will keep Congress informed of our progress.

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS

The Federation of American Hospitals is the national association of investor-owned hospitals representing over 1,100 hospitals with over 135,000 beds. Our member management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all non-governmental hospitals. In many communities, investor-owned facilities represent the only hospital serving the population.

We appreciate this opportunity to submit our comments on the "Alternative Medical Liability Act", H.R. 5400. As we enter this new era of constrained spending and changed incentives, hospitals realize anew the need for a rational malpractice liability system. Providers of health care are greatly concerned about the increase on costs associated with medical malpractice claims. While working to develop good risk management programs and to provide cost effective quality health care, we find the present malpractice system inequitable to both providers and patients and a contributing factor to increased health care costs.

We applaud the timeliness of the introduction of this legislation by Representatives Moore and Gephardt. All participants in the health care system can point to increases in health care costs represented by higher hospital and physician charges due to the practice of defensive medicine, as well as higher malpractice insurance and health insurance premiums. We hope this legislation will provide a framework for input from all affected parties to develop a workable and equitable solution.

Enactment of the Medicare DRG based prospective payment system, development of health maintenance organizations (HMOs), preferred provider organizations (PPOs) and various capitation reimbursement systems all pressure hospitals to eliminate any unnecessary procedures not related to delivering cost effective quality treatment. Tests and procedures performed defensively rather than therapeutically are no longer reimbursed unquestioningly by government or other third party payers. Hospitals therefore find themselves in a catch twenty-two situation in that the new reimbursement systems calls for reducing procedures while the potential threat of high cost liability for malpractice stimulates doing more. The present malpractice system and the currently developing reimbursement systems may force some providers to limit the services they offer which are high risk for malpractice liability. This does not serve the interests of either the provider or the patient. Therefore we welcome the introduction of H.R. 5400 by Representatives Moore and Gephardt as an important starting point for finding a fair answer for both patients and providers to this problem.

The purpose of no fault legislation such as the "Alternative Medical Liability Act" is to provide certain and speedy recovery where injury occurs and economic loss is incurred, without protracted delays to determine fault or liability, or the awarding of extraordinary punitive damages for pain and suffering. It should result in more claims being paid to injured parties than under the current roulette system which often awards large settlements to a few with a large portion of the award

going towards the cost of bringing suit, and excludes other with legitimate claims through long delays and costly litigation.

The result of a fair malpractice system we hope will be to reduce medical costs by reducing the number of tests and procedures related to the practice of "defensive medicine". While no one can exactly determine such costs, the American Medical Association has estimated it to be $15 billion a year in physician costs alone. Hospitals subject to the new Medicare prospective payment system which limits reimbursement per case by diagnosis, have a direct interest in reducing or eliminating to the extent possible, procedures performed to ensure protection from malpractice litigation rather than for their benefit to the patient. While it may prove difficult to identify and quantify such practices, we should at least give physicians and hospitals an environment which allows them to practice medicine and deliver health care for the well being of their patients rather than solely to defend themselves from charges of malpractice.

It should be noted when discussing cost savings to be achieved through no fault malpractice legislation, that there may well be procedures not currently performed in some instances because on balance, the physician does not want to risk a charge of malpractice even though the procedure withheld might prove beneficial to the patient. Thus we may see a little overall reduction in health care costs through a no fault system.

Similarly, insurance premiums may not reflect a sharp drop in health care costs since it appears likely that H.R. 5400 will lead to the compensation of many more patients for injury, although for economic loss only, because determination of fault will not be at issue. Summarily, one should not overestimate the savings to be achieved under a no fault system.

Regardless of what dollar savings might be achieved by reform of the medical malpractice system, the present system requires reform to assure continued access to all health care services and the appropriate use of those services as well as fair compensation for those injured by medical malpractice. The Federation believes the "Alternative Medical Liability Act" will help focus Congressional attention on this critical issue and we look forward to working with Representatives Moore and Gephardt as they refine their legislative proposal.

HEALTH INDUSTRY MANUFACTURERS ASSOCIATION,
Washington, DC, July 13, 1984.

Hon. ANDREW JACOBS, Jr.,
Chairman, Subcommittee on Health,
Committee on Ways and Means,
Washington, DC.

DEAR CHAIRMAN JACOBS: The Health Industry Manufacturers Association (HIMA) wishes to add its comments to the record of the hearing on the proposed Alternative Medical Liability Act, H.R. 5400. The Subcommittee on Health conducted this hearing June 28.

HIMA is a national trade association representing more than 300 manufacturers of medical devices and diagnostic products. While the membership includes larger firms, most HIMA companies are small, nearly two-thirds having annual sales of less than $20 million. HIMA companies manufacture a broad spectrum of devices and diagnostics, ranging from disposable medical supplies to high technology items.

The legislation could directly affect HIMA members. Under the legislation, a provider making a tender to pay compensation benefits to an injured individual could join in the proceeding any other potentially liable party, such as a manufacturer. Once joined, a manufacture would pay a portion of the settlement and be protected from a product liability action by the injured individual.

The Association commends Representatives Moore and Gephardt for their sponsorship of the alternative medical liability legislation. The legislation represents an innovative approach for dealing with medical malpractice claims.

While product liability issues are important to many of our members, we do not understand well the impact of medical malpractice claims on the product liability of manufacturers. Consequently, we cannot at this time take a position on H.R. 5400. We do, however, intend to review the proposal more thoroughly with our members and look forward to working with you and your Subcommittee as you explore the issues raised by the proposed legislation.

Thank you for this opportunity to comment.

Sincerely,

FRANK E. SAMUEL Jr., *President.*

NEW YORK MEDICAL LIABILITY REFORM COALITION,
Albany, NY, July 10, 1984.

Hon. ANDY JACOBS, Jr.
U.S. House of Representatives,
Washington, DC.

Dear Mr. JACOBS: On behalf of the New York Medical Liability Reform Coalition, it is my privilege to submit the following written comments concerning the Alternative Medical Liability Act (H.R. 5400).

The New York Medical Liability Reform Coalition is, as its name implies, a coalition of health care providers, health and medical liability insurers and corporate consumers of health care benefits. Among its members are the Medical Society of the State of New York the Hospital Association of the State of New York, Blue Cross/Blue Shield of New York, Medical Liability Mutual Insurance Company, the New York Chamber of Commerce, the Business Council of the State of New York, the Alliance of American Insurers, etc.

The New York Medical Liability Reform Coalition was formed two years ago. Its members were brought together by a deep concern over escalating health care costs and similarly escalating costs of medical liability insurance. The Coalition has proposed various legislative remedies to alleviate these problems, including caps on awards mandatory structured settlements, limitations on attorneys' contingent fees, and tightening of evidentiary rules.

A current Coalition project is a study in depth of alternative liability systems for medical malpractice. It has been a consistent view of members of the Coalition that present methods of dispute resolution are inefficient, expensive and unfair. We welcome H.R. 5400 as a novel approach to a difficult problem and we urge that your Committee continue its study of this and other means of addressing this most serious problem.

Our study is still preliminary. We have not yet had the opportunity, as a Coalition, to address the details of H.R. 5400. We would welcome the opportunity to meet with your staff to share our developing research and to continue what I believe would be an extremely fruitful dialogue on this subject.

Very truly yours,

IRVING J. LEWIS,
Chairman.

PHYSICIAN INSURERS ASSOCIATION OF AMERICA,
Lawrenceville, NJ, July 10, 1984.

JOHN J. SALMON,
Chief Counsel, Committee on Ways and Means,
U.S. House of Representatives,
Washington, DC.

I wish to file a written statement for the record of hearing on this bill on behalf of the Physician Insurers Association of America. Our association is comprised of thirty-six physician owned and directed, medical professional liability insurers located in twenty-six states and the District of Columbia. As a group, we provide malpractice insurance for more than half the country's doctors who purchase the coverage individually or as professional corporations. In the great majority, we can be characterized as non-profit companies seeking to stabilize the problem and improve the quality of health care.

We share the concern expressed by the sponsors of HR 5400 that malpractice suits adversely affect the cost and quality of health care delivery today. We are equally alarmed at the rate of growth of this problem and the increasing difficulty all involved parties are having with the disposition of such cases under the present system. Our association encourages efforts to institute reforms, particularly at the state level where local ideosyncrasies may be addressed.

We fully endorse this bill's objectives of prompt compensation of deserving victims of malpractice and the greater allocation of available money to payment for rehabilitative care. Our initial review of the proposed alternative system finds many features which individual PIAA member companies are supporting in state legislatures today, and we applaud the endorsement provided such concepts as collateral source offsets, encouraged periodic payments, timely full discovery, binding arbitration in value disagreements, controlled legal costs and elimination of the exaggerating features of "pain and suffering" and general damages.

Other features of HR 5400 contain proposals which are new to us and we must state at this time that further study is necessary. It is clear that much time and

effort went into the design of this bill with each ramification thought through all possible effects. Our initial readings have surfaced a number of concerns and, while they are not sufficient to generate opposition to the bill overall, we would like the opportunity to present them and other questions once our study is completed. Some examples of specific concerns raised thus far are: the short period of time allowed to offer compensation in comparison with our claims reporting experience; just who should be empowered to make a settlement offer, since normal policy working precludes insured action; the need for some total liability limit in establishing compensation provisions; and our need for a better understanding of how the "Assigned Claims Plan" and joinder provisions would work.

A more general concern is our need to assess just how many more compensated claimants the alternative system will produce. Over the years that the malpractice problem has grown, most of our membership has steadfastly opposed a broad "no-fault" solution, since every cost analysis made indicates a multifold increase in the dollar impact. On the surface HR 5400 seeks to compensate more individuals without guaranteeing recovery for every unfortunate outcome. We would like to reach our own conclusions on the impact before offering our final opinion.

On balance, we believe that HR 5400 seeks to accomplish many of the objectives sought by our member companies. PIAA is willing to assist in the developmental process which the bill now is likely to undergo. Representatives of our association are willing to sit at any point with drafters of the proposal in hopes of developing a measure which will gain the full support of our membership.

Once more let me say that we appreciate all positive attempts to reform the system which burdens us today, and we sincerely hope that an opportunity will be presented for our further involvement.

Sincerely yours,

JAMES S. TODD, M.D.,
President.

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